

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04927					04920					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
First Middle Last PAUL P. ADLER					Month Day Year APRIL 27, 1969		6:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		9/19/19		49 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
MARYLAND		U.S.A.				BALTIMORE				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD			VETERANS ADMIN. HOSPITAL			SOCIAL WORKER				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND					BALTIMORE				1701 EUTAW PLACE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
MOSES - - ADLER			SARAH - - PLANT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
YES			WWII		212 01 6635 CLINICAL RECORDS, VAH, FT. HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:								DAYS		
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								YEARS		
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
CEREBRAL VASCULAR DISEASE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		State	
22a. I certify that (a) (this hospital) attended the deceased from APR 22, 1969, to APR 27, 1969, that (b) (we) last saw the deceased alive on APR 27, 1969, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Philip M. Ashman</i> DEGREE								22c. DATE SIGNED 4/27/69		
22d. PHYSICIAN'S NAME (Type) PHILIP M. ASHMAN, M.D.								22e. ADDRESS VAH, FT. HOWARD, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		4/28/1969		BALTO. HEBREW CONG. CEM.		BALTIMORE, MD.				
24. FUNERAL DIRECTOR				ADDRESS		25a. RECEIVED BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
				9610 REISTERSTOWN RD. GARRISON, MD.		APR 29 1969		<i>Philip M. Ashman</i>		
SYLVAN LEWIS FUNERAL HOME										

75020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04928 CERTIFICATE OF DEATH 04921										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
MAUDE			EVELYN ALISEA			04 Month 15 Day Year 69		2:55 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
FEMALE		CAU		6-02-04		64 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		U.S.A.				BALTIMORE CO. Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON, MARYLAND			GRTR. BALTO. MED CNTR			Clerk		Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.					Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1026 W. 38th St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
			213-03-6378A		Erma Jackson 1355 W. 42nd St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY FAILURE</u>								IMMEDIATE		
1621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA OF LUNG, BRAIN METASTASIS</u>								6 MONTHS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>2-11</u> , 19 <u>69</u> , to <u>4-15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>B. R. Choi M.D.</u> DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-15-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>B. R. CHOI M.D.</u>					22e. ADDRESS					
23a. BURIAL, CREMATION, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/17/69		St. Mary's		Balto. Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Paul E. Chenoweth 3rd. 3617 Chestnut Ave.					APR 17 1969		<u>Charles Judge</u>			

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04929										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04922	
1. DECEASED NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR	
MARSHALL C. ANDREWS										4 30 69										6:20 P M	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN							
Male		White		April 15, 1882				87 YRS.													
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH													
Ohio			U.S.A.					Baltimore Md.													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY									
Cockeysville				Masonic Home																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
Ohio				—				Cleveland				4250 W. 33rd Street									
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last																	
John Andrews				Isabelle Robertson																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)				17. INFORMANT Address													
				271-07-2789				Masonic Home Records													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage														Months							
4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic Vas. Heart Dis														10 yrs							
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1966, to April 30, 1969, that (I) (we) last saw the deceased alive on April 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE Carl F. Benson, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 4/30/69											
22d. PHYSICIAN'S NAME (Type) Carl F. Benson, M.D.										22e. ADDRESS 5111 York Rd Balto. Md 21212											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
Burial				5-3-1969		Druid Ridge Cemetery				Pikesville Md.											
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson						ADDRESS 1050 York Rd Towson Md. 21204		25a. RECD BY REGISTRAR DATE MAY 6 1969				25b. REGISTRAR'S SIGNATURE J. J. Jones									

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>04930</div> <div>04923</div>									
<div>1. DECEASED-NAME (Type or Print)</div> <div>First Middle Last</div> <div>STANLEY LEWIS ANSELL</div>									
<div>3. SEX</div> <div>Male</div>		<div>4. RACE</div> <div>White</div>		<div>5. DATE OF BIRTH</div> <div>OCT 27, 1926</div>		<div>6. AGE (In years last birthday)</div> <div>42 YRS.</div>		<div>7a. DATE KNOWN OF DEATH</div> <div>ESTIMATED</div> <div>Month Day Year</div> <div>4 16 1969</div>	
<div>7b. BIRTHPLACE (State or foreign country)</div> <div>PENNA.</div>		<div>7c. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>		<div>8. MARRIED</div> <div><input checked="" type="checkbox"/> NEVER MARRIED</div> <div><input type="checkbox"/> WIDOWED</div> <div><input type="checkbox"/> DIVORCED</div>		<div>9. COUNTY OF DEATH</div> <div>Baltimore</div>		<div>2b. HOUR</div> <div>2:15 PM</div>	
<div>10. CITY OR TOWN OF DEATH</div> <div>Woodlawn</div>				<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Milford Mill & Liberty Heights</div>				<div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>TRUCK DRIVER</div>	
<div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Md.</div>				<div>13b. COUNTY</div> <div>CARROLL</div>		<div>13c. CITY OR TOWN</div> <div>New Windsor</div>		<div>13d. INSIDE CITY LIMITS?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>	
<div>14. FATHER'S NAME</div> <div>First Middle Last</div> <div>ELMER ANSELL</div>				<div>15. MOTHER'S MAIDEN NAME</div> <div>First Middle Last</div> <div>JANE CRAMER</div>				<div>13e. STREET AND NUMBER</div> <div>Box 177 New Windsor, Md.</div>	
<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>YES</div>				<div>16b. SOCIAL SECURITY NO.</div> <div>179-20-3361</div>		<div>17. INFORMANT</div> <div>RUTH ANSELL</div>			
<div>16c. ADDRESS</div> <div>RURAL</div>				<div>16d. NEW WINDSOR MD</div>				<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div>	
<div>PART 1. DEATH WAS CAUSED BY:</div>				<div>IMMEDIATE CAUSE (a) Multiple injuries</div>				<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div>	
<div>815.0</div>				<div>DUE TO, OR AS A CONSEQUENCE OF</div>					
<div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</div>				<div>(b) DUE TO, OR AS A CONSEQUENCE OF</div>					
<div>(c) DUE TO, OR AS A CONSEQUENCE OF</div>									
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)</div>									
<div>19a. DATE OF OPERATION</div>				<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div>				<div>20. AUTOPSY?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>	
<div>21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/></div>				<div>21b. TIME OF INJURY Month, Day, Year</div> <div>HOUR A.M.</div> <div>2:15 PM 4 16 19 69</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)</div> <div>Subject driver in truck-fixed object collision</div>			
<div>21d. INJURY OCCURRED</div> <div>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></div>				<div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> <div>Street</div>		<div>21f. LOCATION Street or R.F.D. No. City or Town County State</div> <div>Milford Mill & Liberty Heights Balto. Md.</div>			
<div>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>									
<div>ACTUAL SIGNATURE</div> <div>EXAMINER'S NAME (Type)</div>				<div>Edward F. Wilson, M.D.</div>				<div>22b. DATE SIGNED</div> <div>4/16/69</div>	
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div>				<div>23b. DATE</div> <div>APRIL 19-1969</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>EVERGREEN GARDENS</div>		<div>23d. LOCATION (City or Town) (County) (State)</div> <div>FINKSBURG MD</div>	
<div>24. FUNERAL DIRECTOR</div> <div>ADDRESS</div>				<div>DD Hartzler + Sons New Windsor</div>				<div>25a. REC'D BY REGISTRAR</div> <div>DATE APR 18 1969</div>	
								<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>	

05230

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
304M REV. 6-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last GRACE Pearl ARMAEOST						2a. DATE OF DEATH Yrs. Month Day Apr. 13		2b. HOUR 8:45		M	
3. SEX F		4. RACE Cauc.		5. DATE OF BIRTH March 1, 1889		6. AGE (In years last birthday) 80		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.					
10. CITY OR TOWN OF DEATH Monkton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) York Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Monkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER York Rd.	
14. FATHER'S NAME First Middle Last James Almon				15. MOTHER'S MAIDEN NAME First Middle Last Elista Standiford							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b. SOCIAL SECURITY NO. 212-28-3461A		17. INFORMANT Address Mrs. Thelma E. Knouse, Parkton, MD 21120					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. A. V. d-ism 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1950 , to 4/13 , 1969 , that (I) (we) last saw the deceased alive on 4/10/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE A. M. France md						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/14/69	
22d. PHYSICIAN'S NAME (Type) A. M. FRANCE						22e. ADDRESS PARKTON, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/16/69		23c. NAME OF CEMETERY OR CREMATORY Fosters Cemetery		23d. LOCATION (City or Town) (County) (State) Monkton-Balto-Md.					
24. FUNERAL DIRECTOR James J. Hartenstein, New Freedom, Pa.						25a. REC'D BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04932										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04925									
1 DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR									
Harry N. ARMACOST										4 5 69										1:04 AM									
3. SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)			7 UNDER 1 YEAR MONTHS DAYS			7 UNDER 24 HRS. HOURS MIN.														
Male			White			Feb. 15, 1886			83 YRS.																				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Baltimore			U.S.A.						Baltimore Md.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Baltimore			House In The Pines-Catonsville			Funeral Director																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Md.			Baltimore			Baltimore			YES			4204 Ridgewood Avenue																	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Ellsworth Armacost					Dora Annie I. Newnam																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
No					212-36-3379					Marion P. Armacost-4600 Liberty Hghts. Av																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction															2108														
DUE TO, OR AS A CONSEQUENCE OF (b) Ch. Myocarditis															832														
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis															835														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 2-18, 1969, to 4-5, 1969, that (I) (we) last saw the deceased alive on 4-4-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED														
Wilmers K. Gallager, Sr. M.D.															4-7-69														
22d. PHYSICIAN'S NAME (Type) Wilmers K. Gallager, Sr. M.D.										22e. ADDRESS 2309 Sandwich Ave. Balt. Md. 21228																			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)																				
Burial			4-8-69			Woodlawn Cemetery			Baltimore, Maryland																				
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
Armacost Funeral Chapel-4600 Liberty Hghts										APR. 8 1969					Charles Judge														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
John Forrest ASH						April Month 9 Day 1969 Year		11:30		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
Male		White		Jan. 1, 1920		49 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Oklahoma		U.S.A.				Baltimore Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Fort Howard			Veterans Administration Hospital			Guard		Detective Agency		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland					Baltimore				843 Glade Court	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Kenneth Ash			Pauline Kean							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
Yes WW-11			314 05 41 80		Clinical Rcds, VA Hospital, Fort Howard, Md.					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CORONARY THROMBOSIS										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar 26, 19 69, to April 9, 19 69 that (I) (we) last saw the deceased alive on April 9, 19 69, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (d) (do) view the body after death.										
22b. SIGNATURE J. D. Talbert, M.D.					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/10/69			
22d. PHYSICIAN'S NAME (Type) J. D. TALBERT, M.D.					22e. ADDRESS VA Hospital, Fort Howard, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/14/69		Baltimore National		Baltimore Maryland				
24 FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
FISHER FUNERAL HOME				1930 Eastern Ave. Balto, Md.		APR 15 1969				

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04934

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04927

1 DECEASED NAME (Type or Print) DURWOOD O. ASHWORTH			2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year 19 19			2b HOUR M		
3 SEX male	4 RACE white	5 DATE OF BIRTH 1-20-1914	6 AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year April 28, 1969		
7a BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cost Analyst		12b KIND OF BUSINESS OR INDUSTRY Railroad		
13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) - STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Govans		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 405 Croydon Road
14 FATHER'S NAME First Middle Last Lawrence Wellington Ashworth				15 MOTHER'S MAIDEN NAME First Middle Last Maude Ashworth				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give war or dates of service) 718-16-8275		17. INFORMANT ADDRESS Mrs. Lillian Ashworth 405 Croydon Rd. 21212				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Werner U. Spitz, M.D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/28/69		
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 5-2-1969		23c NAME OF CEMETERY OR CREMATORY Westhampton Memorial Park		23d LOCATION (City or Town) (County) (State) Richmond, Virginia		
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Road 21204				25a REC'D BY REGISTRAR MAY 1 1969		25b REGISTRAR'S SIGNATURE <i>Lillian Ashworth</i>		

04935

CERTIFICATE OF DEATH

04928

1. DECEASED-NAME (Type or print)		First RICHARD	Middle A.	Last AVARITT SR.	2a. DATE OF DEATH Month 4/ Day 30/ Year 69		2b. HOUR 9:25AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11/3/26		6. AGE (In years last birthday) 42		7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE		
10. CITY OR TOWN OF DEATH PORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) VET. ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR INDUSTRY SHIPYARD		
13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE Chase		13d. NO. OF LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 474 Cornell Road
14. FATHER'S NAME First Ollie		Middle AVARITT		15. MOTHER'S MAIDEN NAME First MAMIE DOMBROWSKI		Middle AVARITT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 218 22 58 70		17. INFORMANT CLIN. RECORDS, VA HOSP. FT HOWARD, MD.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL 5/1/69 Conditions, if any, which gave rise to immediate cause (b) CIRRHOSIS OF LIVER stating the underlying cause (c) last								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) this hospital attended the deceased from 4/26/69 , 19__, to 4/30/69 , 19__, that (X) (we) last saw the deceased alive on 4/30/69 , 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE John D. Talbert, M.D.		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/30/69		
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22e. ADDRESS VAH FT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 5/3/69		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILLS CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.		
24. FUNERAL DIRECTOR JOHN J. DUDA FUNERAL HOME, INC.		ADDRESS 7922 WISE AVENUE, DUNDALK, MD.		DATE REC'D BY REGISTRAR 2 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M

APR 30 1969

04936		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04929	
CERTIFICATE OF DEATH					
1. DECEASED NAME (Type or print) First <i>Ella</i> Middle <i>AYERS</i> Last <i>(AYERS)</i>		2a. DATE OF DEATH 4 Month 26 Day 69 Year		2b. HOUR M	
3 SEX <i>FEMALE</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>July 21, 1885</i>	
6 AGE (In years lost birthday) <i>83</i> YRS.		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>BALTO.</i>				Md.	
10. CITY OR TOWN OF DEATH <i>Catonville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Balto</i>	
13d. INSIDE CITY, M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>431 Raleigh Rd</i>			
14. FATHER'S NAME First <i>William</i> Middle <i>Curtis</i> Last <i></i>		15. MOTHER'S MAIDEN NAME First <i>Margaret</i> Middle <i>Ann</i> Last <i></i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes, give year or dates of service)		16b. SOCIAL SECURITY NO <i>215-07-1506D</i>		17. INFORMANT <i>Mrs. Margaret O'Neara</i>	
				Address <i>7918 Dunhill Village Baltimore Md. 21207</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intensified to cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiovascular accident, Right heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>2/25, 1969</i> to <i>4/26, 1969</i> , that (I) (we) last saw the deceased alive on <i>4/26, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>E. KASHITSIS, M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. DATE SIGNED <i>4/26/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>E. KASHITSIS, M.D.</i>		22e. ADDRESS <i>1001 F. B. R. Rd. Baltimore, Md. 21228</i>			
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 30, 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cem.</i>	
23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>					
24. FUNERAL DIRECTOR <i>Louise B. Byers</i>		ADDRESS <i>Liberty Rd.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 30 1969</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04937

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04930

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Orville			H.	Aylor	April Month 21 Day 69 Year		4:15 P M		
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male	White		4-20-1882		87 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Virginia	USA				Baltimore County Md				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Balto. 12		Holly Hill Nursing Home		U.S. Gov't. Printing, Retired					
13a USUAL RESIDENCE (Where deceased lived; if institution Residence before adm'ssion) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.		Baltimore		Balto. 10		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4 Hillside Rd. 21210	
14. FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Robert		H. Aylor		Anna Virginia Childs					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
No		578-50-7069		Richard H. Wood		4 Hillside Rd. 21210			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastric ulcer</u>								6 mo	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <u>OCTOBER 25 1968</u> , to <u>APRIL</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>APRIL</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED	
<u>Joseph D.B. King</u>								<u>APRIL 22 1969</u>	
22d PHYSICIAN'S NAME (Type)				22e ADDRESS					
<u>JOSEPH D.B. KING</u>				<u>2 HAMILL Road - Balto. Md.</u>					
23a BURIAL, CREMATION, REMOVAL, SPECIFY		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Rem. Burial		April 24, 1969		Beahms Chapel		Luray Va.			
24 FUNERAL DIRECTOR		4905 York Road Balto		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co.		21212, Md		APR 22 1969		<u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 1 hour after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04938

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04931

1. DECEASED-NAME (Type or print) <i>Mame</i>		First <i>M</i>		Middle <i>Azzarello</i>		Last		2a. DATE OF DEATH Month <i>APRIL</i> Day <i>6</i> Year <i>69</i>			2b. HOUR <i>8:40 AM</i>	
3. SEX <i>F</i>		4. RACE <i>W.</i>		5. DATE OF BIRTH <i>5-03-09</i>		6. AGE (In years last birthday) <i>59</i> YRS.		F UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Balto.</i>			MD.			
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Balto. County General</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>NONE</i>		12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Randalls.</i>		3d. INS DE CITY L.M.T? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Box 190A Liberty Rd.</i>				
14. FATHER'S NAME First <i>Santo</i> Middle <i>Azzarello</i> Last		15. MOTHER'S MAIDEN NAME First <i>Kattie</i> Middle <i>nmi</i> Last <i>Palmisano</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>		16b. SOCIAL SECURITY NO <i>none</i>		17. INFORMANT Address <i>Balto. County General Hospital</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C.V.A.</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>HYPER TENSION.</i> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Acute Myocardium Infarction.</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>APRIL 5, 1969</i> to <i>APRIL 6, 1969</i> , that (I) (we) last saw the deceased alive on <i>APRIL 6, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Boon Vanasin</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>April 6, 69</i>								
22d. PHYSICIAN'S NAME (Type) <i>BOON VANASIN</i>		22e. ADDRESS <i>Balto. County Gen. Hosp.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/6/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i>						
24. FUNERAL DIRECTOR <i>Loring Byers</i>		ADDRESS <i>8728 Liberty Rd. Randallstown</i>		25a. REC'D BY REGISTRAR DATE <i>APR 9 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

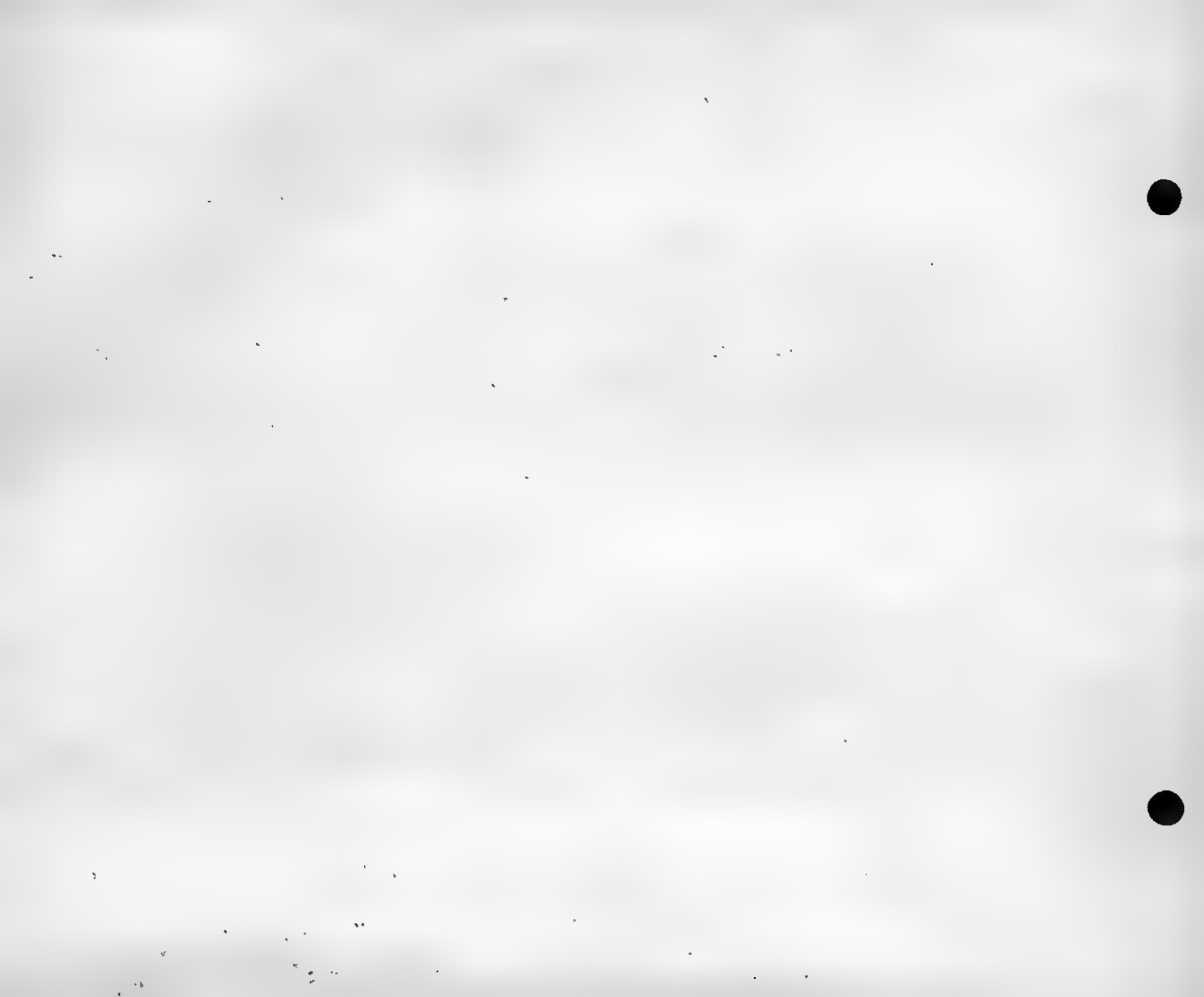
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04939

CERTIFICATE OF DEATH

04932

1. DECEASED NAME (Type or print) <i>Harry Norman Baetjer</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>5</i> Year <i>69</i>			2b. HOUR <i>4:30 A</i>	
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>JAN. 12. 1882</i>		6. AGE (In years last birthday) <i>87</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARR.ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i>	
10. CITY OR TOWN OF DEATH <i>Stevenson</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>-</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Lawyer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Law</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Prest</i>		13c. CITY OR TOWN <i>Stevenson</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>Valley Road</i>		14. FATHER'S NAME First <i>JOHN</i> Middle <i>GEORGE</i> Last <i>BAETJER</i>		15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>ANNA</i> Last <i>KOPPLEMAN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>213-34-1406</i>		17. INFORMANT <i>Mrs. Lenora Hartley, Stevenson, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.C.V.P.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>17 Jan</i> , 19 <i>67</i> , to <i>5 April</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3 June</i> 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles H. Williams</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-5-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Charles H. Williams</i>				22e. ADDRESS <i>Pikesville, 21208, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>APRIL 7, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GREEN MOUNT CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE Md.</i>	
24. FUNERAL DIRECTOR <i>HENRY W. JENKINS & SONS, Co. 4905 YORK ROAD.</i>				25a. REC'D BY REGISTRAR <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 04940 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04933 </div>																				
1. DECEASED NAME (Type or print)			First George			Middle Lotes			Last Baldwin			2a. DATE OF DEATH Month Day, Year April 5, 1969			2b. HOUR 2:40 P.M.					
3. SEX male			4. RACE white			5. DATE OF BIRTH Aug. 15, 1886			6. AGE (In years last birthday) 82 YRS.			7. UNDER 1 YEAR MONTHS DAYS			8. UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Canada			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.											
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) engineer			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Pr. Geol.			13c. CITY OR TOWN Adelphi			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 9250 Edwards Way								
14. FATHER'S NAME First Middle Last George P. Baldwin			15. MOTHER'S MAIDEN NAME First Middle Last Annie Martha Ann Scott																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 577-36-7938			17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure and</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 13, 1969</u> , to <u>April 5, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																				
22b. SIGNATURE <u>Rafael H. Marin</u>			DEGREE M.D.			ATTENDING PHYS <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 1-5-69					
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.			22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/9/69			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.			23d. LOCATION (City or Town) (County) (State) Suitland, Md.											
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.			ADDRESS Mt. Rainier, Maryland			25a. REC'D BY REGISTRAR DATE APR 11 1969			25b. REGISTRAR'S SIGNATURE Charles Judge											

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04941

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04934

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
Joseph				Bales	ESTIMATED		Apr.	21	19 69	11:05 M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years past birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD		Month	Day	Year
Male	White	May 10, 1906	62 YRS			April		21	19 69	11:30 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Ohio		U. S. A.				Baltimore		Md.		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Edgemere		2925 Salisbury Ave.		Retired-Bethlehem Steel Co.						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Baltimore		Edgemere		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2925 Salisbury Ave.		
14. FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
Paul				Bales	Anna				?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT (Daughter)		ADDRESS				
		070-10-4876		Mrs. Rita Maranovich, 3102 River Drive Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
CAUSE OF DEATH		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Theodore C. Patterson		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/22/69		
EXAMINER'S NAME (Type)		Theodore C. Patterson		M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3724 Dundalk Ave.		
						ADDRESS (Street, city, town, or county)		Dundalk, Md. 21222		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		4/24/69		Gardens of Faith Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John J. Duda, 7922 Wise Ave. Dundalk, Md.						APR 25 1969		Charles Judge		

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 412 5-8-61 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												04935			
04942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print) HAYWOOD						First Middle Last BANKS						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/> M			
3 SEX Male		4. RACE Negro		5. DATE OF BIRTH 11-25-1901		6 AGE (in years next birthday) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month April Day 25 , Year 1969		2d. HOUR 9:35 P	
7a. BIRTHPLACE (State or foreign country) N.C. CAROLINA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. General Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 312					
14. FATHER'S NAME First Middle Last PRESTON BANKS						15. MOTHER'S MAIDEN NAME First Middle Last ALICE ?									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO 237-16-7531		17. INFORMANT ADDRESS 407 SHEPARD ST ELIZABETH CITY N.C.									
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Bronchogenic Carcinoma with Multiple Metastases															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. COND TION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Ronald N. Kornblum		EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/26/69					
ADDRESS (Street, city, town, or county)															
23a. BURIAL CREMATION, REMOVA. (Specify) BURIAL		23b. DATE 4-4-1969		23c. NAME OF CEMETERY OR CREMATORY LEE SAWYERS CEM.				23d. LOCATION (City or Town) (County) (State) ELIZABETH CITY N.C.							
24. FUNERAL DIRECTOR Wm. H. Haight		ADDRESS Seaside, Md.		25a. REC'D BY REGISTRAR MAY 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMO: Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04943

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04933

1. DECEASED-NAME (Type or Print)		First RICHARD		Middle N.		Last BARANOWSKI		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> April 24, 1969		2b. HOUR 9:10 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 15, 1921		6. AGE (In years last birthday) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month April Day 24 Year 1969		2d. HOUR 10:20 AM
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md.					
10. CITY OR TOWN OF DEATH Baltimore (Essex)		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7746 Eastdale Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Route Salesman-Ice Cream Co.		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7746 Eastdale Road			
14. FATHER'S NAME First Joseph		Middle Baranowski		Last		15. MOTHER'S MAIDEN NAME First Beatrice		Middle Drozdowski		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO (If yes, give war or dates of service) 213-14-3859		17. INFORMANT Mrs. Anna T. Baranowski		ADDRESS (Same)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-Disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		MELVIN B. DAVIS M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/25/69 ADDRESS (Street city town, or county) 6800 KENNINGTON RD JUNDOLPH					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/28/69.		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		County		State	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div style="text-align: center;"> <p>CERTIFICATE OF DEATH</p> </div> <div style="text-align: right;"> <p>04937</p> </div> </div>																															
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Baltimore</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Powers Avenue</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u></p> <p>d. STREET ADDRESS <u>Powers Avenue</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>																											
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Rebecca D.</u> Middle <u>Barbour</u> Last</p>				<p>4. DATE OF DEATH</p> <p>Month <u>April</u> Day <u>14</u> Year <u>1969</u></p>				<p>5. SEX <u>Female</u></p>				<p>6. COLOR OR RACE <u>White</u></p>				<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>				<p>8. DATE OF BIRTH <u>February 13, 1886</u></p>				<p>9. AGE (In years last birthday) <u>83</u> yrs.</p>				<p>IF UNDER 1 YEAR Months Days Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Cun Home</u></p>				<p>11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>																			
<p>13. FATHER'S NAME <u>Joseph Eaton</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Margaret Rice</u></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u></p>				<p>16. SOCIAL SECURITY NO.</p>				<p>17. INFORMANT <u>Family records</u> Address</p>															
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Amphiphysia (Left Hemisphere)</u></p> <p>45 7 DUE TO <u>Thromboses</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>												<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>																			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>																											
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. 19</p>				<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>																			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1966</u>, to <u>April 13, 1969</u>, that (I) (we) last saw the deceased alive on <u>April 13, 1969</u>, and that death occurred at <u>7P</u> M, from the causes and on the date stated above.</p>																															
<p>22a. SIGNATURE <u>Theodore G. de la Cruz, M.D.</u></p> <p>22c. PHYSICIAN'S NAME (Type) <u>Theodore G. de la Cruz, M.D.</u></p>												<p>22b. DATE SIGNED</p>				<p>22d. ADDRESS <u>733 Herdill Rd. Kutherville Md. 21093</u></p>															
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>				<p>23b. DATE THEREOF <u>April 17, 1969</u></p>				<p>23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u></p>				<p>23d. LOCATION (City, town or county) (State) <u>Cockeysville, Maryland</u></p>																			
<p>24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u></p>								<p>25a. REC'D BY REGISTRAR <u>Charles Judge</u></p> <p>25b. REGISTRAR'S SIGNATURE</p> <p>DATE <u>APR 18 1969</u></p>																							

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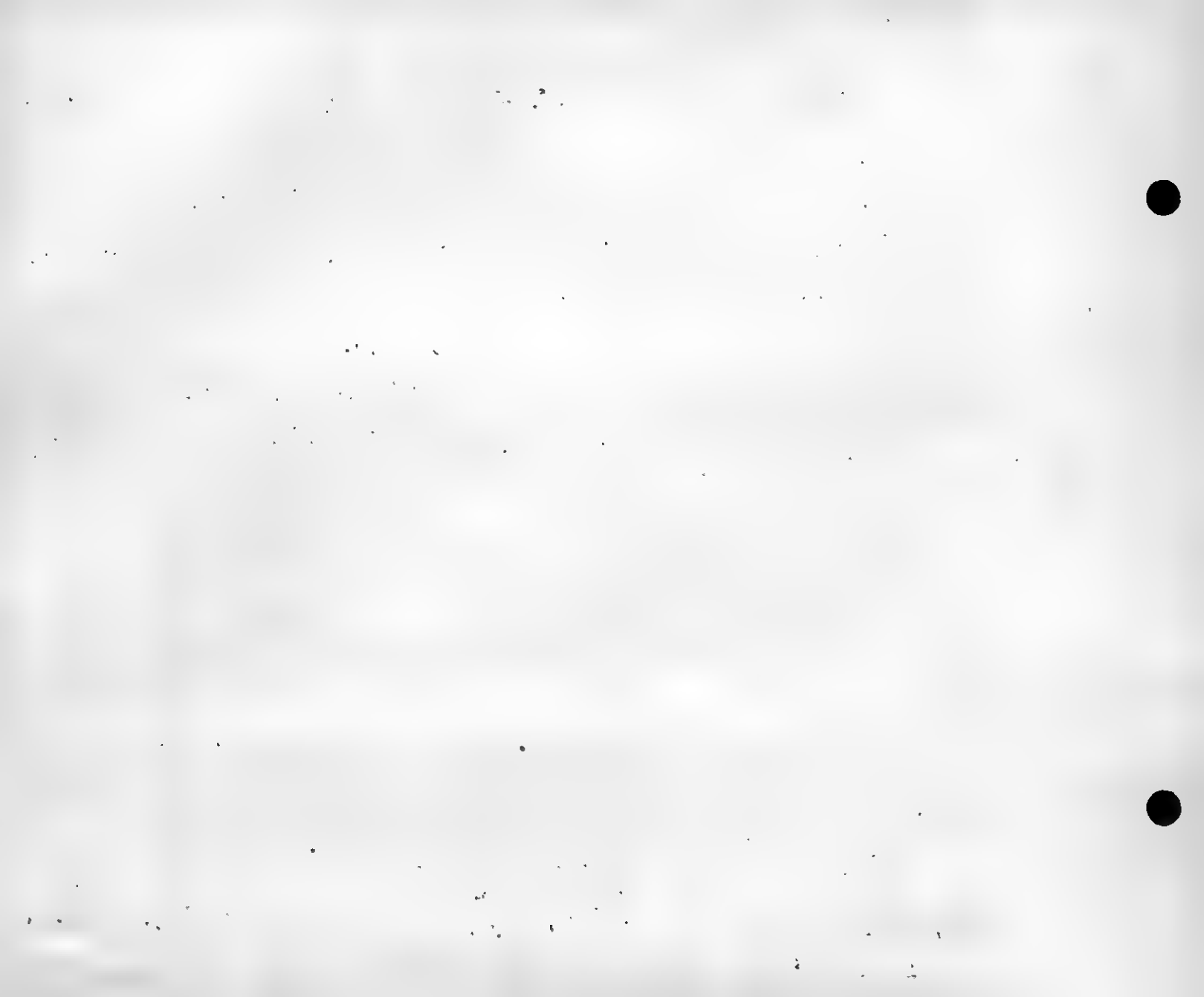
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> 04945 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04938 </div> <div style="display: flex; justify-content: space-between;"> Item 5 Film 412 4/30/69 kk CERTIFICATE OF DEATH </div>																
1. DECEASED-NAME (Type or print)			First MARIE			Middle -			Last BARTES			2a. DATE OF DEATH Month APRIL Day 17 Year 89			2b. HOUR 8:30 A.M.	
3. SEX Female			4. RACE W			5. DATE OF BIRTH 2/26/1884			6. AGE (In years lost birthday) 85 YRS			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS M.N.		
7a. BIRTHPLACE (State or foreign country) Hungary			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.							
10. CITY OR TOWN OF DEATH Calumville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b. KIND OF BUSINESS OR INDUSTRY None							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New Jersey			13b. COUNTY -			13c. CITY OR TOWN HANOVER			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER UNKNOWN				
14. FATHER'S NAME First Unknown Middle - Last -			15. MOTHER'S MAIDEN NAME First Unknown Middle - Last -			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. -			17. INFORMANT Mrs. Helen Padula			Address Woodstock, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastric - contents DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) - stating the underlying cause lost. (b) - DUE TO, OR AS A CONSEQUENCE OF (c) -													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 day			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from 4/11/69 , 19 69 , to Apr 17 , 19 69 that (I) (we) lost saw the deceased alive on 16 Apr , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE William Goodman, M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>													22c. DATE SIGNED 17 Apr 69			
22d. PHYSICIAN'S NAME (Type) WILLIAM GOODMAN, M.D.			22e. ADDRESS 1334 Lupton St. N.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-20-69			23c. NAME OF CHURCH OR CREMATORY St. Joseph's			23d. LOCATION (City or Town) (County) (State) HANOVER, Md. N.J.							
24. FUNERAL DIRECTOR Harry W. Haight			Address Likewise, Md.			25a. REC'D BY REGISTRAR DATE APR 22 1969			25b. REGISTRAR'S SIGNATURE William J. E.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

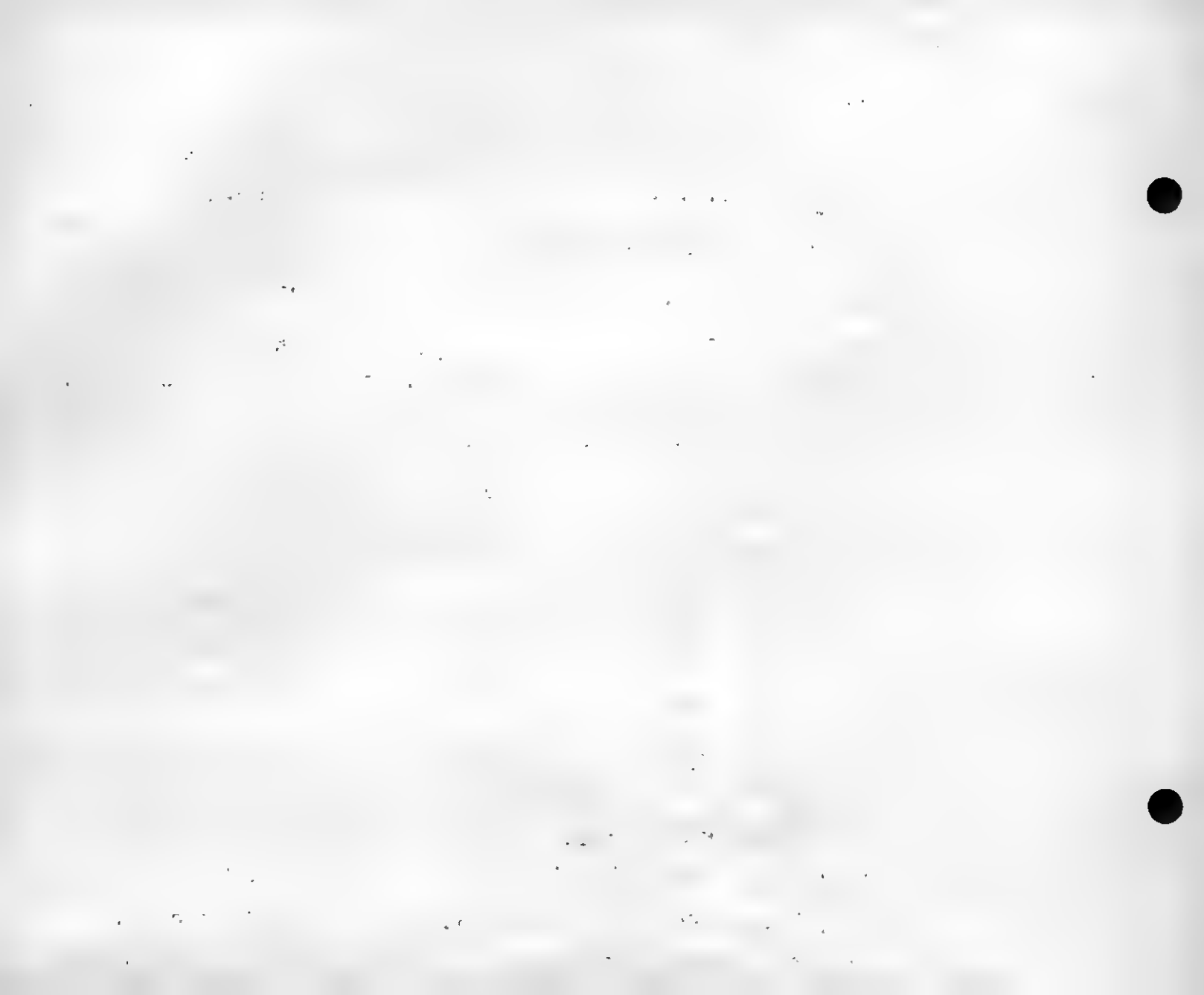
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04946

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

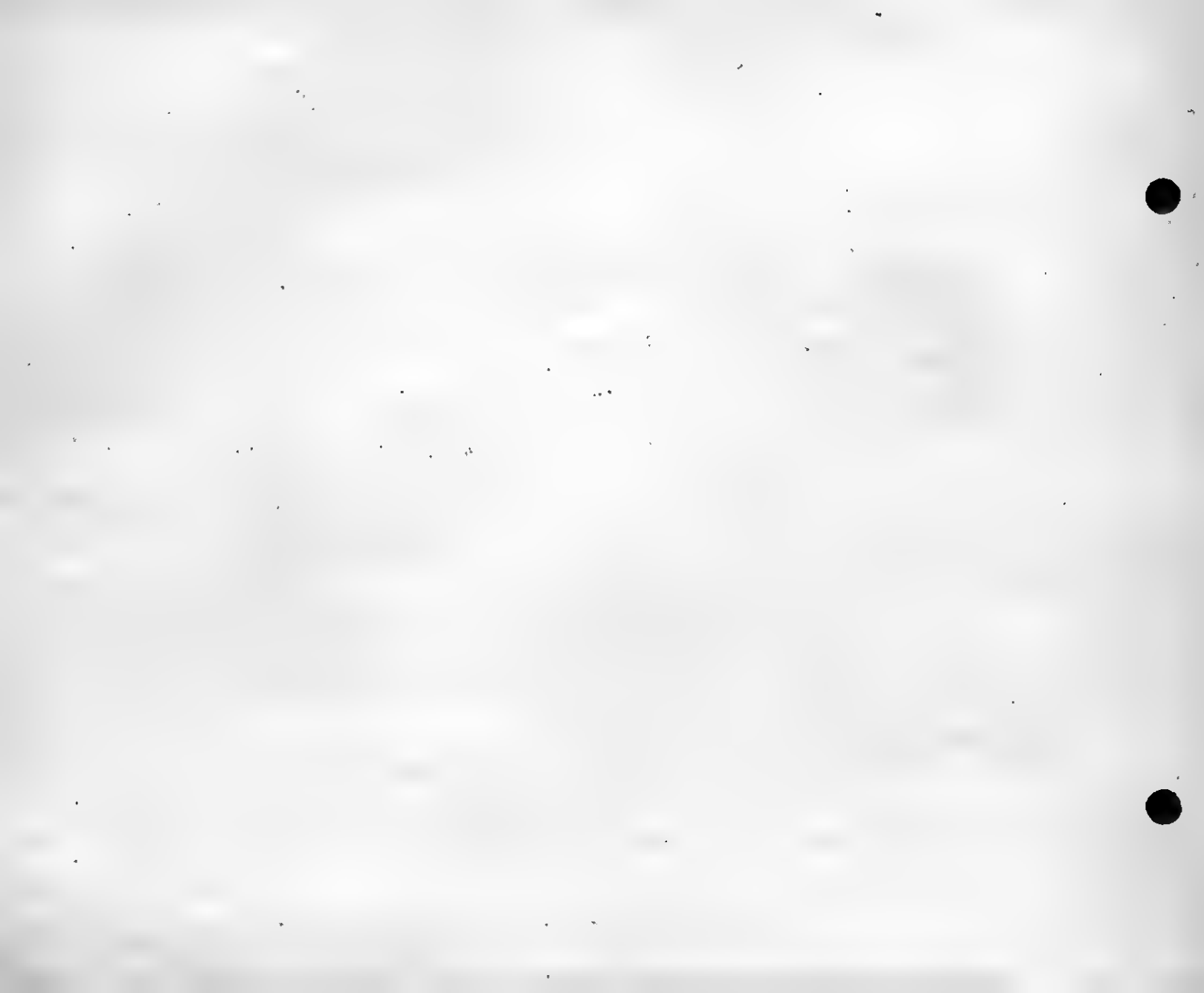
04939

1. DECEASED-NAME (Type or print) David Wade Basch			2a. DATE OF DEATH 4 Month 21 Day 69 Year			2b. HOUR 10:09 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 4/18/69		6. AGE (In years last birthday) 3 days	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE Md.		13b. CITY Balto.		13c. CITY OR TOWN Overlea		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 339 Elinor Ave.		14. FATHER'S NAME First Middle Last Robert Lee Basch		15. MOTHER'S MAIDEN NAME First Middle Last Joanne Faith Scagg		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	
16b. SOCIAL SECURITY NO. -		17. INFORMANT Robert L. Basch - 339 Elinor Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema and anoxia 7761 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Asphyxia neonatorum DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/19, 1969, to 4/21, 1969, that (I) (we) lost saw the deceased alive on 4/21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. Breitenecker				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/22/69	
22d. PHYSICIAN'S NAME (Type) Rudiger Breitenecker, M.D.				22e. ADDRESS 6701 N. Charles St. Balto. Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-23-69		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John C. Miller Inc 06415 Belair Rd.				25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
06423											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JOSEPH		C.				BATCHELOR		April Month 27 Day 1969 Year		7A M	
3 SEX		4 RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR	
M		W						65 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wilson, N.C.		U.S.A.				Baltimore Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Cockeysville, Md.		519 Lord Byron Lane				Security Guard					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Cockeysville, Md.		BALTO.		Cockeysville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		319 Byron St.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Emmerson C.		Batchelor						UNKNOWN.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address					
		233-34-3864		Thomas Yelverton F.H.		Wilson, N.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 1621										6 mos.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1967, to April 25, 1969, that (I) (we) last saw the deceased alive on April 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
William P. Benson, Jr. M.D.		April 27, 1969		WILLIAM P. BENSON, JR.		3502 NCALVERT BALT, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Evergreen Mem. Garden		4/29/69		Wilson		BALTO.		MD.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wm. J. Tickner & Sons		MAY 12 1969		DATE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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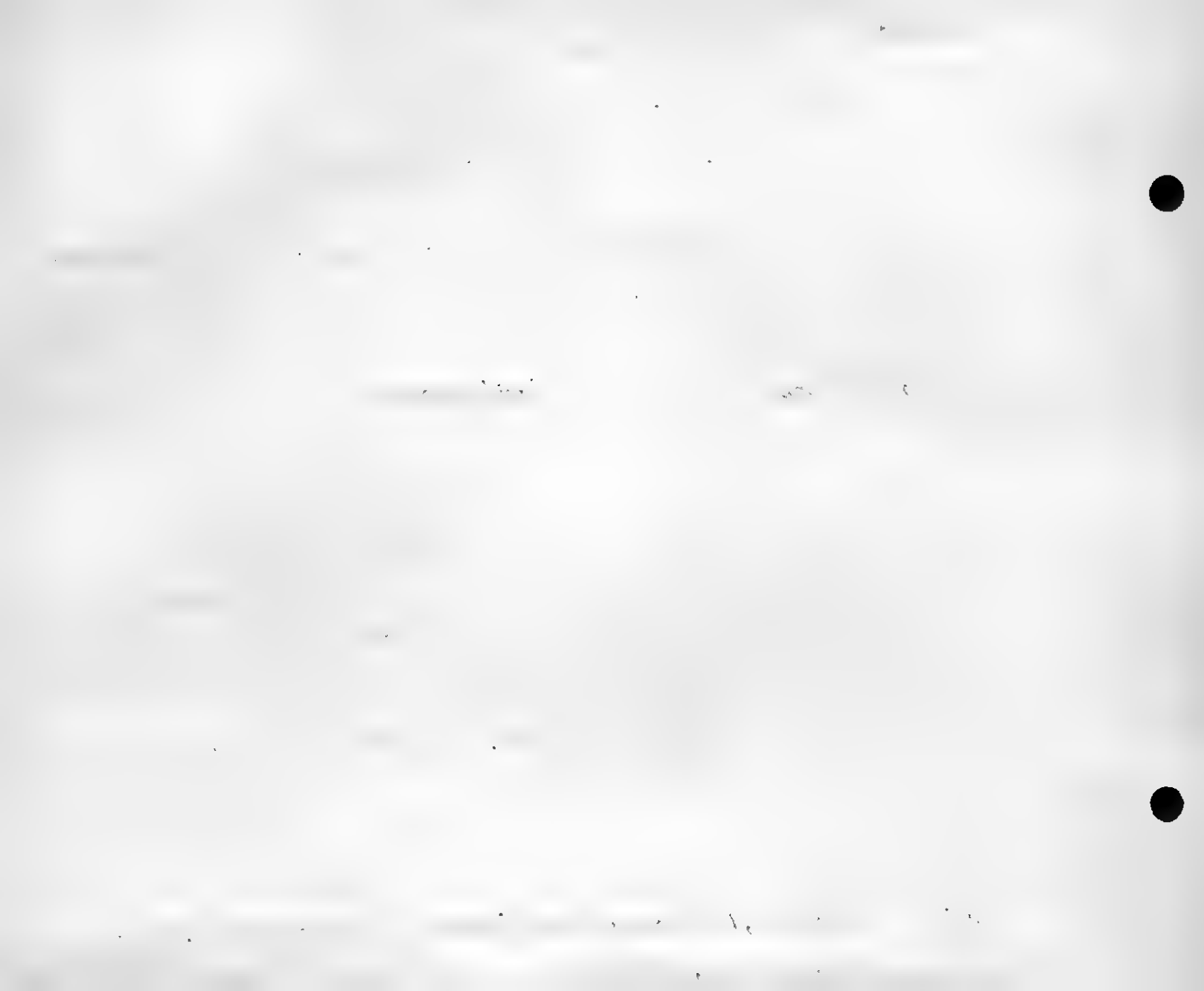
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04948

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04940

1 DECEASED NAME (Type or print)		First Edith	Middle Ida	Last Baugher	2a. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>69</u>		2b. HOUR <u>5.05</u> P		
3 SEX <u>Female</u>		4 RACE <u>White</u>		5 DATE OF BIRTH <u>Nov. 9, 1981</u>		6 AGE (In years last birthday) <u>87</u> YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <u>New Windsor, Md</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Balto. Co.</u>			Md.
10 CITY OR TOWN OF DEATH <u>Towson, Md.</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Dulaney-Towson Nursing Home</u>				12a USUAL OCCUPATION (Kind of work done during most of work on life, even if retired) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>		13b COUNTY <u>Balto. Co.</u>		13c CITY OR TOWN <u>Towson</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <u>324 Aigburth Rd. 21204</u>	
14 FATHER'S NAME		First <u>Charles</u>	Middle <u>W.</u>	Last <u>Wood</u>	15 MOTHER'S MAIDEN NAME		First <u>Mary</u>	Middle <u>Ida</u>	Last <u>Ingle</u>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <u>No</u>		16b SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT <u>Family records</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIOSCLEROSIS</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 <u>69</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>JUL</u> , 19 <u>64</u> , to <u>APRIL 19, 1969</u> , that (I) (we) last saw the deceased alive on <u>APRIL 14, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>I. C. Siwinski</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>21 APR 69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Dr. Thaddeus Siwinski</u>					22e. ADDRESS <u>206 W. Penna. Ave. Towson, Md. 21204</u>				
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>		23b. DATE <u>April 23, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>					25a. RECEIVED BY REGISTRAR <u>APR 23 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>		



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04949

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04941

DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Mollie		Corbett		Belton	April 21, 1969		3:45	
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	Negro		5/3/26		42 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Virginia	U. S. A.				Baltimore County Md.			
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		Spring Grove State Hospital			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Baltimore City		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 514 N. Calhoun St.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
William		Corbett		Louise Corbett				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT				
		245-62-7363		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular-accident</u> 4330 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerosis, hypertension.</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/12/68</u> , 19 <u>68</u> , to <u>April 21, 1969</u> , that (I) (we) lost saw the deceased alive on <u>April 21, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
<u>Diondis Pirovolidis</u>		4-21-69						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Diondis Pirovolidis, M.D.		Spring Grove State Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
<u>Removal</u>		4-23-69		<u>Little Ginye Grove</u>		<u>Sampson Co., N.C.</u>		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<u>William S. Phillips</u>		DATE <u>APR 24 1969</u>		<u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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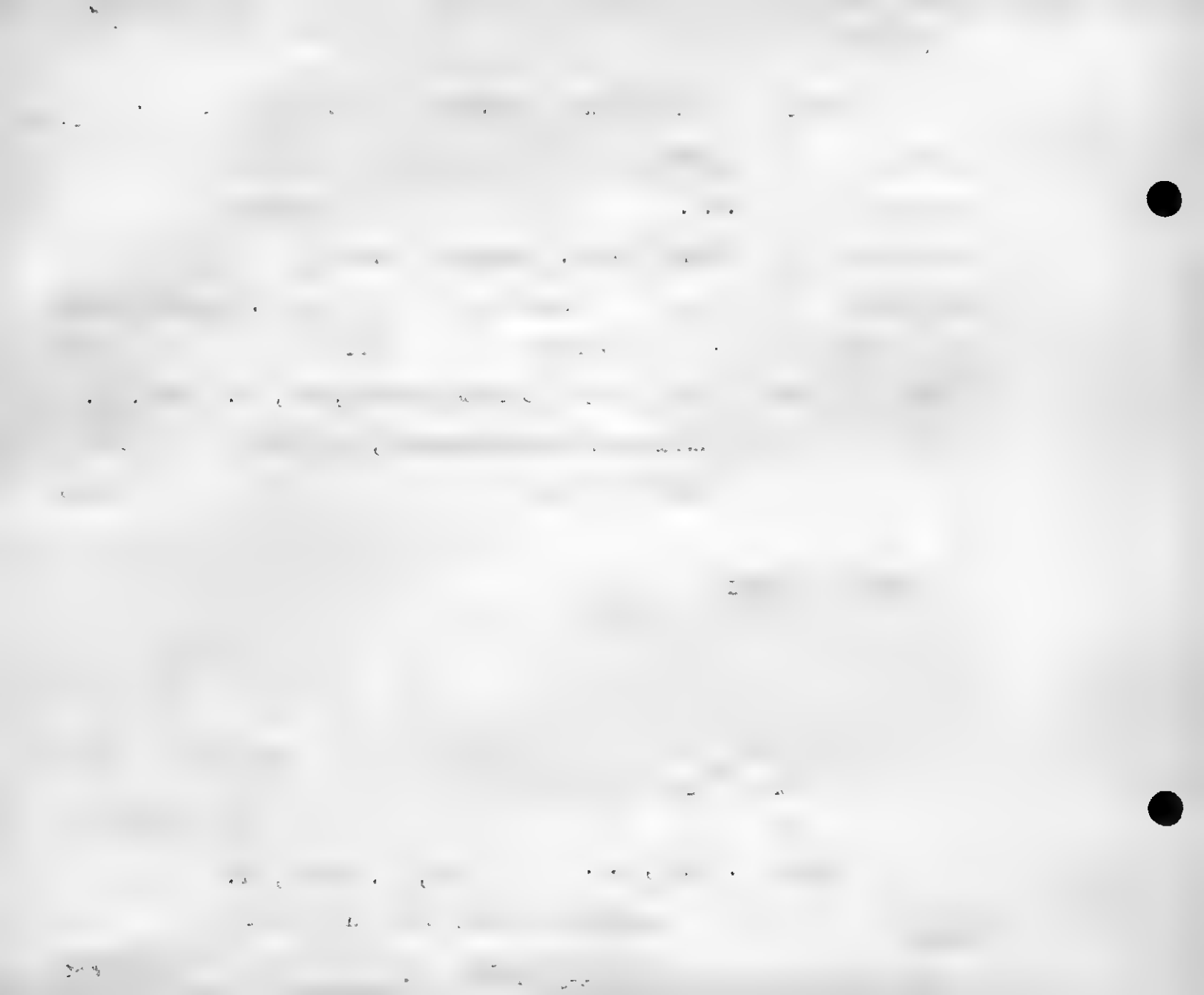
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04950

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04942

1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR			
THEODORE ROOSEVELT BENJAMIN						APRIL 18, 1969			3:00A M			
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		NEGRO		10/8/06			62 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md			
MARYLAND		U.S.A.				BALTIMORE						
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD			VETERANS ADMIN. HOSPITAL			PRINTER						
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND						BALTIMORE				638 W. FRANKLIN STREET		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME									
CARL - - BENJAMIN			MARY - - CLARK									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address			
YES WWII			027 09 0353			CLINICAL RECORDS, VAH, FT. HOWARD, MD.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPIRATION BRONCHOPNEUMONIA, BOTH LUNGS										DAYS		
3329 DUE TO, OR AS A CONSEQUENCE OF DUODENAL ULCER										MONTHS		
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
LAENNEC'S CIRRHOSIS												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. Month Day Year P.M. 19									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)			21f LOCATION			City or Town County State			
						Street or R.F.D. No						
22a. I certify that (x) (this hospital) attended the deceased from MAR 13, 1969, to APR 18 1969, that (we) saw the deceased alive on APR 18 19 69, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.												
22b SIGNATURE						DEGREE			22c DATE SIGNED			
ALPHONSO A. LOPEZ, M.D.						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			4 19 69			
22d PHYSICIAN'S NAME (Type)						22e ADDRESS						
						VAH, FT. HOWARD, MD.						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
BURIAL			4/23/69		BALTIMORE NATIONAL CEMETERY			BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
Morton & Dyett 1702-31 LAURENS ST.						APR 21 1969			Charles Judge			



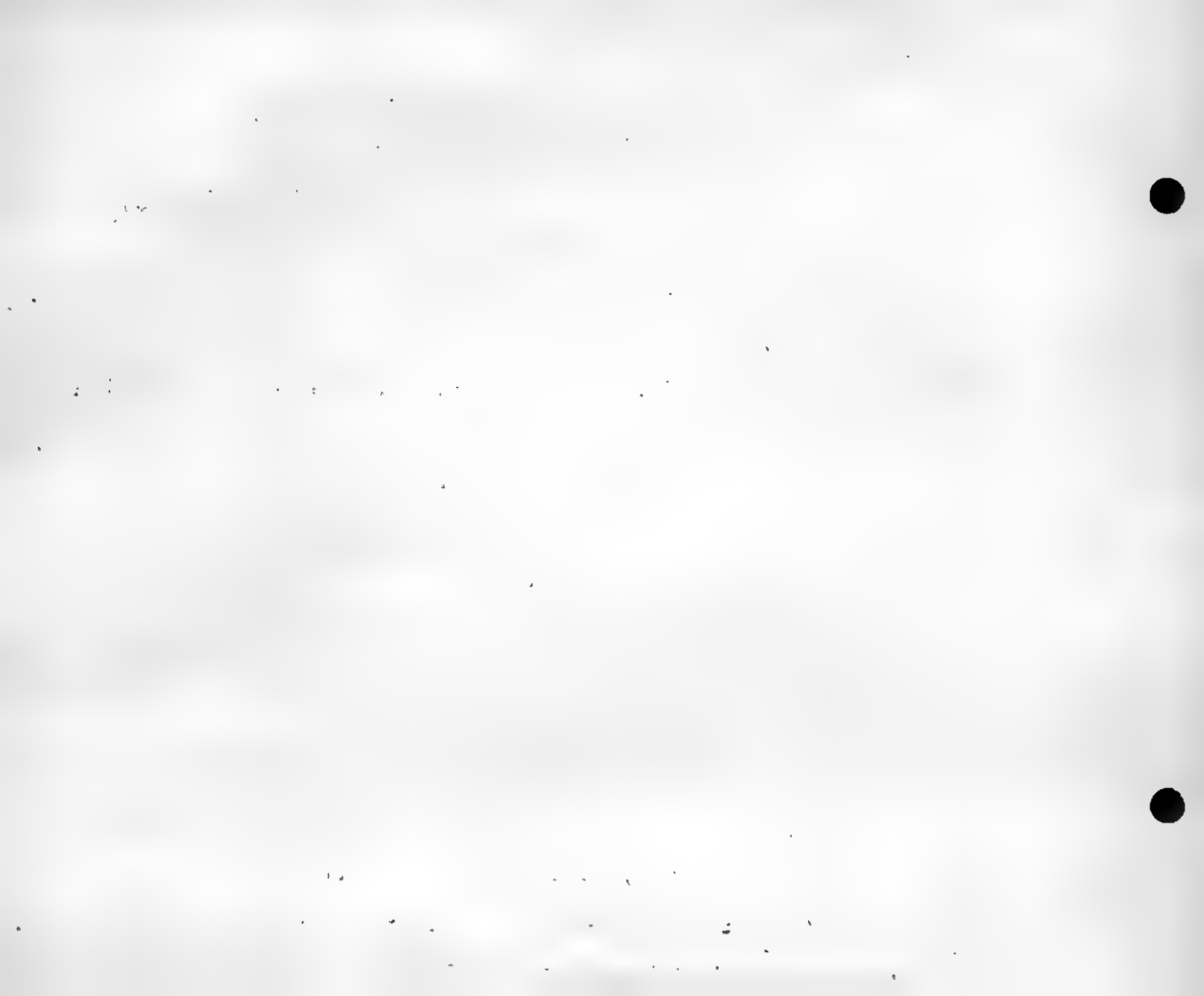
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04951

04943

1. DECEASED NAME (Type or print) NOLA MARIE BENNETT			2a. DATE OF DEATH Month 4 Day 9 Year 1969		2b. HOUR 3:30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 5-7-06		6. AGE (In years last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) W. VA	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore County, Md		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hosp. Mt Wilson State	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution admission) STATE MD	13b. COUNTY CUMBERLAND	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Rt. 1 Box 120 CASHA Valley	
14. FATHER'S NAME First LEE Middle HARPER Last BENNETT	15. MOTHER'S MAIDEN NAME First NEVA Middle DOVE Last BENNETT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 213-48-9567	17. INFORMANT Address Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE COR PULMONALE (RESPIRATORY ACIDOSIS) TLCX DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EMPHYSEMA, BRONCHIAL ASTHMA. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC BRONCHITIS.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W Newcomer		DEGREE M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/9/69	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4/11/1969	23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens	23d. LOCATION (City or Town)	(County)	(State)
Burial			Near Cumberland Alleg		Md.
24. FUNERAL DIRECTOR John J. Hafer, Jr.		ADDRESS 230 Baltimore Ave Cumberland	25a. REC'D BY REGISTRAR APR 11 1969	25b. REGISTRAR'S SIGNATURE W. Newcomer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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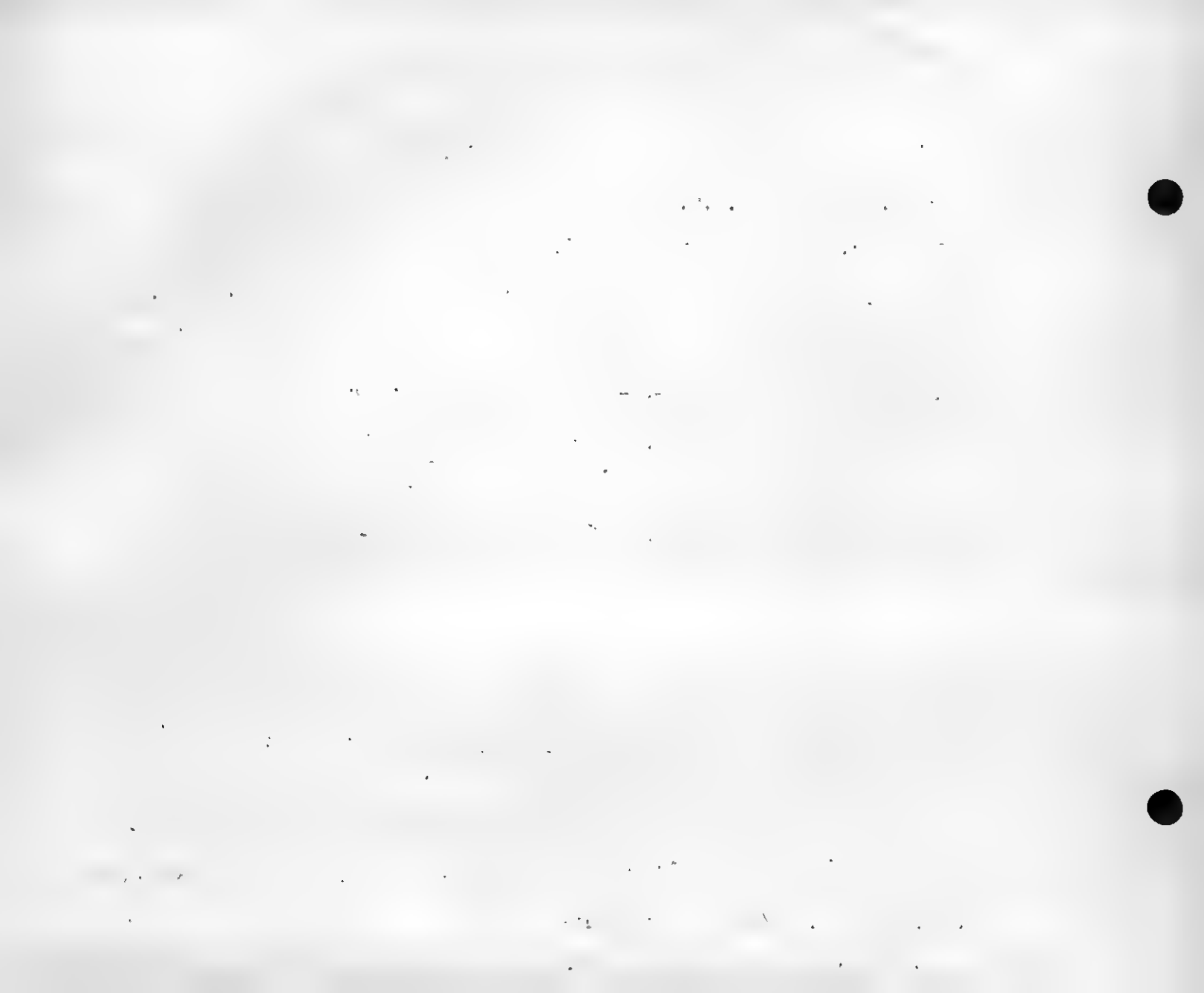
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04952

CERTIFICATE OF DEATH

04944

1. DECEASED NAME (Type or print) JOSEPHINE ^{First} BERGER ^{Last}		2a. DATE OF DEATH APRIL Month 25 , Day 1969 Year		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 13, 1907	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (In years last birthday) 61 YRS.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home		9. COUNTY OF DEATH Baltimore	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
14. FATHER'S NAME First Middle Last Andrew Valenzia		15. MOTHER'S MAIDEN NAME First Middle Last Theresa Battaglia		12b. KIND OF BUSINESS OR INDUSTRY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 213-01-7786		17. INFORMANT Address Mr John A Berger 5720 Fenwick Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of the lungs DUE TO, OR AS A CONSEQUENCE OF (b) Addison Disease DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from February 19 69 to April 25 19 69 , that (I) (we) last saw the deceased alive on April 21 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Henry Arman M.D.		22c. DATE SIGNED 4/25/69		22d. PHYSICIAN'S NAME (Type) HENRY ARMAN (S)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/28/69		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		25a. REC'D BY REGISTRAR APR 28 1969	
25b. REGISTRAR'S SIGNATURE Charles J. J...					



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04955		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04945	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First		Middle		Last			
Bessie				Berman			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)	
Female		White				84 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Russia		U.S.A.				Balto. Co. Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson, Md.		Dulaney-Towson Nursing Home		HOUSEWIFE		AT HOME	
13a. USUA. RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Balto.		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER			
First Middle Last		First Middle Last		6109 Park Heights Ave.			
Aaron		SHAPIRO		UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		NO		MRS. IRVIN GREENBERG,		3737 CLARKS LANE #15	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronch pneumonia</u>							<u>if death</u>
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Coronary Artery Hypertension</u>							<u>20 years +</u>
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
		HOUR A.M. Month Day Year					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1936</u> to <u>4-22-69</u> , that (I) (we) lost the deceased alive on <u>3-15-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<u>M. Jacobson M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<u>4-22-69</u>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Dr. Meyer Jacobson				6821 Reisterstown Rd. Balto. Md. 21215			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		4-24-69		SHAAREI ZION		ROSEDALE, MARYLAND	
24. FUNERAL DIRECTOR				25a. DATE OF REGISTRATION		25b. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				APR 25 1969		<u>[Signature]</u>	
VR A13 45M				DATE			

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VR 15-54
45M

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
04954										
04946										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
JOHN HENRY BEVANS, JR.						April Month 4 Day 1969			10:45 M	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		1/13/94		75 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
MARYLAND		U.S.A.				BALTIMORE				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INST. TLT ON (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during part of week before death)		12b KIND OF BUSINESS OR INDUSTRY				
FORT HOWARD		ADMINISTRATION HOSPITAL		SHEET METAL WORKER		ROOFING				
13a USUAL RESIDENCE (Where deceased lived, admission) STATE		13b. CITIZEN OF WHAT COUNTRY?		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND		BALTIMORE		TOWSON				515 E. JOPPA ROAD		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
JOHN HENRY BEVANS			JULIA BAINES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT Address				
YES WW-1			215 07 0769			Clinical Rcds, VA Hospital, Fort Howard, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4364</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis, cerebro</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>vascular accident</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>OLD C.V.A. AND SPASTIC PARALYSIS (R.)</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 10</u> , 19 <u>67</u> , to <u>April 4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <u>Erhard J. Bunyor M.D.</u>						22c. DATE SIGNED 4 4 69				
22d. PHYSICIAN'S NAME (Type) <u>ERHARD J. BUNYOR, M.D.</u>						22e. ADDRESS VA Hospital, Fort Howard, Md.				
23a. BURIAL, CREMATION, OTHER (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		4/7/69		PARKWOOD CEMETERY		BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR		25a. REGISTRATION DATE		25b. FUNERAL HOME ADDRESS		25c. FUNERAL HOME ADDRESS				
		APR 7 1969		5305 Harford Road BALTIMORE, Md.		J. J. J. J.				

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<div>04955</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>04947</div>												
1 DECEASED NAME (Type or print) ANNA						First Middle Last		2a. DATE OF DEATH Month 4 Day 10 Year 69			2b HOUR 8:57	
3 SEX F		4. RACE CAU		5 DATE OF BIRTH 9-26-94/93			6 AGE (in years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS	
7a BIRTHPLACE (State or foreign country) UKRAINE			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md				
10 CITY OR TOWN OF DEATH BALTIMORE			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) GBMC			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b KIND OF BUSINESS OR INDUSTRY			
13a USAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b COUNTY Baltimore		13c CITY OR TOWN Towson		13d INSIDE CITY L.M. 157? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3e STREET AND NUMBER 1116 Chatterleight Circle			
14 FATHER'S NAME First John Middle Bohachos Last Bohachos			15. MOTHER'S MAIDEN NAME First Katherine Middle Zirre Last Zirre									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b SOCIAL SECURITY NO —			17 INFORMANT Stephen Ryan Address 1116 Chatterleight Circle						
18 CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE ANEMIA - G. I. BLEEDING 5310 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) LARGE GASTRIC ULCER - LESSER DUE TO, OR AS A CONSEQUENCE OF (c) CURVATURE - CONGESTIVE HEART FAILURE											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that he (this hospital) attended the deceased from 4/3 , 19 69 , to 4/10 , 19 69 , that he (we) last saw the deceased alive on 4/10 , 19 69 , and that in the (my) (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (do not) view the body after death.												
22b. SIGNATURE Malcolm C. Sheppard						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-10-69				
22d. PHYSICIAN'S NAME (Type) DR. MALCOLM C. SHEPPARD						22e ADDRESS 6701 N. CHARLES ST., BALTO., MD.						
23a B. RIAL, CREMATION, REMOVAL (Specify)			23b DATE 4/14/69		23c NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Md.				
24 FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.						ADDRESS 1501 E. Fort Avenue			25a. REC'D BY REGISTRAR APR 15 1969		25b REGISTRAR'S SIGNATURE Charles J. J...	

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1

04956

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

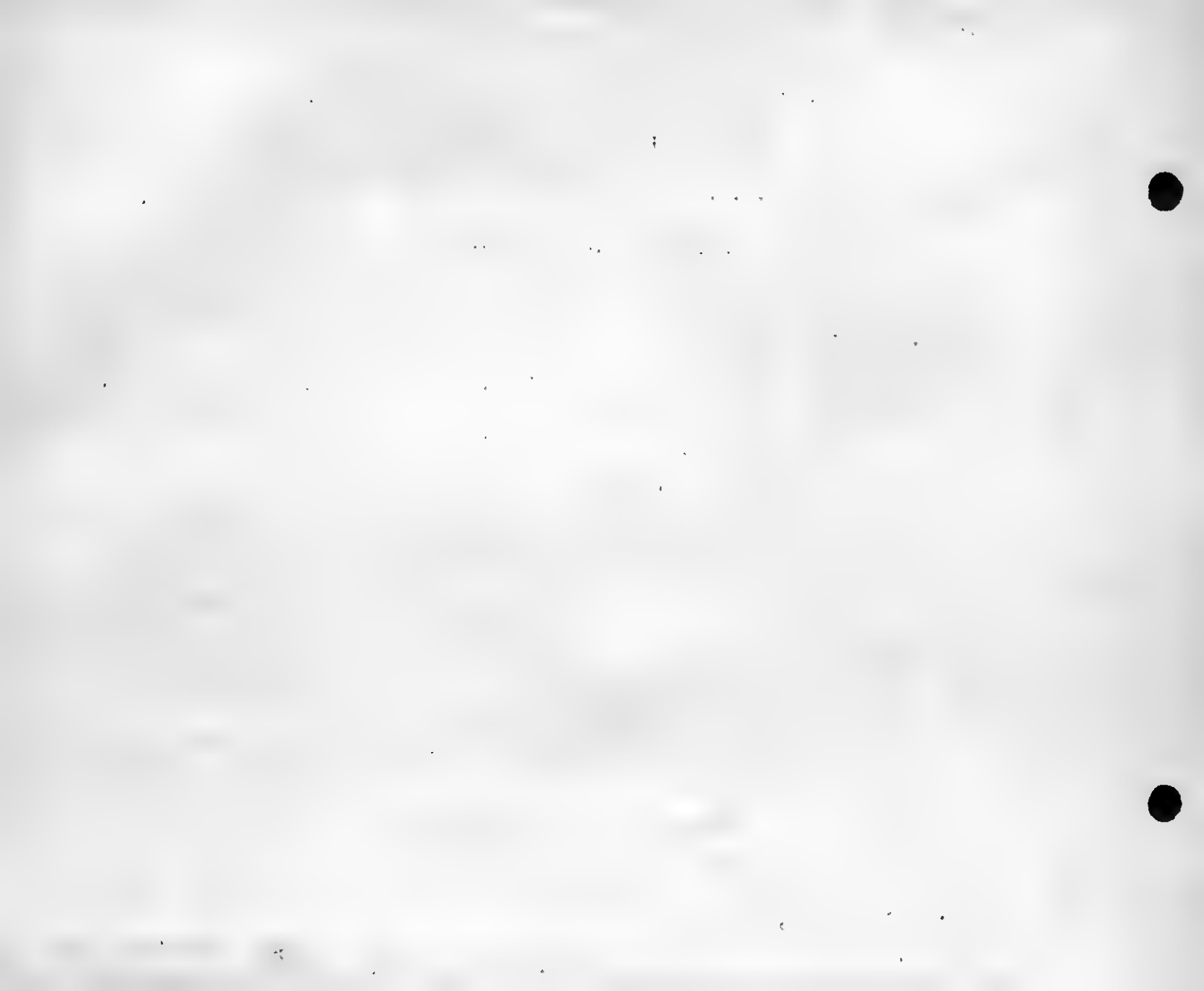
04948

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>69</u>			2b HOUR <u>12:45</u> A.M.		
3 SEX <u>male</u>			4 RACE <u>white</u>		5 DATE OF BIRTH <u>Aug. 5, 1912</u>			6 AGE (In years lost birthday) <u>56</u> YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS
7a BIRTHPLACE (State or foreign country) <u>Md.</u>			7b CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <u>Baltimore</u>				
10 CITY OR TOWN OF DEATH <u>Catonsville</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>SPRING GROVE STATE HOSP.</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Laborer</u>			12b KIND OF BUSINESS OR INDUSTRY <u>Industry</u>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>			13b COUNTY <u>Balto.</u>		13c CITY OR TOWN <u>Sparrows Pt.</u>		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e STREET AND NUMBER <u>7122 River Drive Road</u>		
14 FATHER'S NAME <u>Richard J. Blair</u>			First	Middle	Last	15 MOTHER'S M.A.D.E.N NAME <u>Emily Kahl</u>			First	Middle	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>			(If yes give war or dates of serv. etc.)			16b SOCIAL SECURITY NO. <u>217-01-8851</u>			17 INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepato-renal failure - 2 1/2 weeks days</u> <u>4/23</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>A.S.H.D. with congestive heart failure days</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		State	
22a I certify that (I) (this hospital) attended the deceased from <u>March 11, 1968</u> to <u>April 25, 1969</u> , that (I) (we) lost saw the deceased alive on <u>April 25, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Albert M. Gutierrez, M.D.</u>			DEGREE PHYS.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED <u>4-25-69</u>			
22d PHYSICIAN'S NAME (Type) <u>ALBERT M. GUTIERREZ, M.D.</u>			22e ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Baltimore, Maryland 21228</u>								
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b DATE <u>4/28/69</u>		23c NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>			23d LOCATION (City or Town) (County) (State) <u>Parkville, Balto. Co., Md.</u>			
24 FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>			ADDRESS <u>4905 York Rd.</u> <u>Balto. 12, Md.</u>			25a REC'D BY REG. STRAR <u>APR 28 1969</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

<div>04957</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Items taken from birth cert. CERTIFICATE OF DEATH</div> <div>04949</div>												
1 DECEASED-NAME (Type or print) <u>Bloomfield, Baby Andrew Boy Kenneth</u>						2a DATE OF DEATH 4 Month 26 Day 69 Year			2b HOUR 2:55 M			
3 SEX Male		4 RACE Caucasion		5. DATE OF BIRTH 4/26/69			6 AGE (In years last birthday) YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore Md					
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med.Center			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.				13b COUNTY Harford		13c CITY OR TOWN Joppa		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 419 Acadia Road		
14. FATHER'S NAME First Middle Last Capt. Kenneth Bloomfield				15. MOTHER'S MAIDEN NAME First Middle Last Rose Miriam Chilton								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown				16b SOCIAL SECURITY NO.		17 INFORMANT Address Capt. Kenneth Bloomfield, 419 Acadia Rd. Joppa, Md						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 7769 IMMEDIATE CAUSE (a) Pulmonary atelectasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM STREET FACTORY OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from April 26, 1969, to April 26, 1969, that (I) (we) last saw the deceased alive on April 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE John E. Adams						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/27/69				
22d PHYSICIAN'S NAME (Type) John E. Adams, M. D.						22e ADDRESS 6701 North Charles St. Balto. Md. 21204						
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE May 2, 1969		23c NAME OF CEMETERY OR CREMATORY West Point Cemetery			23d LOCATION (City or Town) (County) (State) West Point, New York					
24. FUNERAL DIRECTOR Harry H. Witzke, 4112 Columbia Pike, Ellicott City, Md. 21043						25a REC'D BY REG. STRAR DATE MAY 2 1969		25b REG. CLERK'S SIGNATURE John E. Adams				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
0495S		CERTIFICATE OF DEATH						04950					
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR		
MAGDALENA			TERESA		BOND		APRIL		Month 28, Day 1969		1:45 AM		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		WHITE		DECEMBER 15, 1882			86 YRS		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
MARYLAND		U.S.AA.				BALTIMORE							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
TOWSON			ST. JOSEPH HOSPITAL			Housewife			at home				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
MARYLAND			Baltimore		Perry Hall				9912 FORGE PK. RD. #21128				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
Hartman									unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		21128				
					Anthony Miller, son,		9912 Forge Pk. Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY 4109 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Vascular Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from MARCH 1, 1969, to April 28, 1969, that (X) (we) lost the deceased alive on APRIL 28, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death													
22b. SIGNATURE Hallafania						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED April 28, 1969					
22d. PHYSICIAN'S NAME (Type) A. Villafania, M.D.						22e. ADDRESS 7620 York Road Towson, Maryland #2124							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial			5/1/69		New Cathedral Cem.		Baltimore, Md.						
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane						25a. REC'D BY REGISTRAR MAY 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

FOR STATE
HEALTH DEPT.

Items 23a thru 24
film 44-25/16/69 jcp
04959

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04952

1. DECEASED NAME (Type or Print) KIM TRACY BOWERS						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year 4-2 1969			2b. HOUR OF DEATH MATED <input type="checkbox"/> 3:04 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7-19-62		6. AGE (In years last birthday) 6 YRS		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN 0		
7a. BIRTHPLACE (State or foreign country) Baltimore			7b. CITIZENSHIP OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Balt. County			
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and number) Balt. County General Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student			12b. KIND OF BUSINESS OR INDUSTRY Student	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE MD				13b. COUNTY Balt. CITY OR TOWN Randallstown				13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4015 Rowen Rd.		
14. FATHER'S NAME First Robert Middle Bowers Last Bowers				15. MOTHER'S MAIDEN NAME First Claine Middle Hampin Last Hampin								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) No				16b. SOCIAL SECURITY NO				17. INFORMANT Mr Robert Bowers ADDRESS 4015 Rowen Rd.				
8. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death the result of being hit by a truck - resulting in compound DUE TO, OR AS A CONSEQUENCE OF (b) amended fracture of left skull DUE TO, OR AS A CONSEQUENCE OF (c) lost Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month Day Year 4-2 3:04 PM 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) while crossing street hit by truck				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) on street				21f. LOCATION Street or R.F.D. No City or Town County State Rowen Rd. Balt County MD				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Robert B. Taylor MD M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 4-2-69				
EXAMINER'S NAME (Type) Robert Bruce Taylor				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/4/69		23c. NAME OF CEMETERY OR CREMATORY Chizuk Amuno (Arlington)				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Sol Levinson & Bros., 6010 Reisterstown Road				ADDRESS				25a. REC'D BY REGISTRAR DATE MAY 16 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) SOPHIE L. BOWERS						2a. DATE OF DEATH 4 Month 22 Day 69 Year			2b. HOUR 6:10 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH AUGUST 5, 1890			6. AGE (In years lost birthday) 78 YRS.		F UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) ST. JOSEPH, MISSOURI		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7928 DUNHILL VILLAGE CIRCLE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY AT HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7928 DUNHILL VILLAGE CIRCLE				
14. FATHER'S NAME First Middle Last SOLOMON SACHS				15. MOTHER'S MAIDEN NAME First Middle Last BESSIE SEGALL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO				16b. SOCIAL SECURITY NO. 212-38-0536A		17. INFORMANT Address MR. STANLEY I. BOWERS, 7114 MINNA ROAD #7						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute 3 YRS		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from June , 19 67 , to April , 19 69 , that (I) (we) last saw the deceased alive on April 12 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Leon G. Sheer, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/22/69				
22d. PHYSICIAN'S NAME (Type) LEON G. SHEER, M.D.						22e. ADDRESS 6715 PARK HEIGHTS, BALTO. MD						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-24-69		23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH				23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD						25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE William J. Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04961

04953

1. DECEASED-NAME (Type or print) Emily Jane Brandenburg			2a. DATE OF DEATH Month April Day 15 Year 1969			2b. HOUR M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH Feb. 20, 1893		6 AGE (In years last birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Co.	
10. CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 47 Overbrook Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) School Teacher		12b. KIND OF BUSINESS OR IND-STRY Balto. City	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 47 Overbrook Rd.							
14. FATHER'S NAME First Middle Last Stephen A. Brandenburg			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Crst				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b SOCIAL SECURITY NO. 214-38-2790A		17 INFORMANT Catonsville, Md. Address Miss. Ethel Brandenburg 47 Overbrook Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Resection of sigmoid 5 years ago due							
(c) to adenocarcinoma							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/15 , 19 22 , to 4/15 , 19 69 , that (I) (we) last saw the deceased alive on 4/15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Damian P. Palajka		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/15/69	
22d. PHYSICIAN'S NAME (Type) DAMIAN PALAJKA		22e ADDRESS 3306 Frederick Ave					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE April 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d LOCATION (City or Town) (County) (State) Woodlawn, Balto. Md.	
24 FUNERAL DIRECTOR G. Truman Schwab		ADDRESS Balto. Md. 21229		25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE Wm. A. O'Connell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04962

CERTIFICATE OF DEATH

04954

1. DECEASED-NAME (Type or print) Julius E Brandt Sr			2a. DATE OF DEATH Month April Day 12 Year 69			2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 18, 1890		6. AGE (In years last birthday) 78 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Forest Haven Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Contractor, Retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Balt.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1727 Carswell St		
14. FATHER'S NAME First Middle Last Ernest P Brandt			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth B ?								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 212-26-5265		17. INFORMANT Address Julius Brandt Jr 10410 Greentop Rd						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 BACTERIAL SCLEROTIC PERICARDIUM - KIDNEY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC HEART FAILURE AND DUE TO, OR AS A CONSEQUENCE OF ACUTE CIRCULATORY COLLAPSE (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/11 , 19 66 , to 4/12 , 19 69 , that (I) (we) last saw the deceased alive on 4/12 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John H Shaw M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/14/69			
22d. PHYSICIAN'S NAME (Type) John H Shaw M.D.				22e. ADDRESS 5800 Edmonson Ave Baltimore Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/15/69		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 14 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

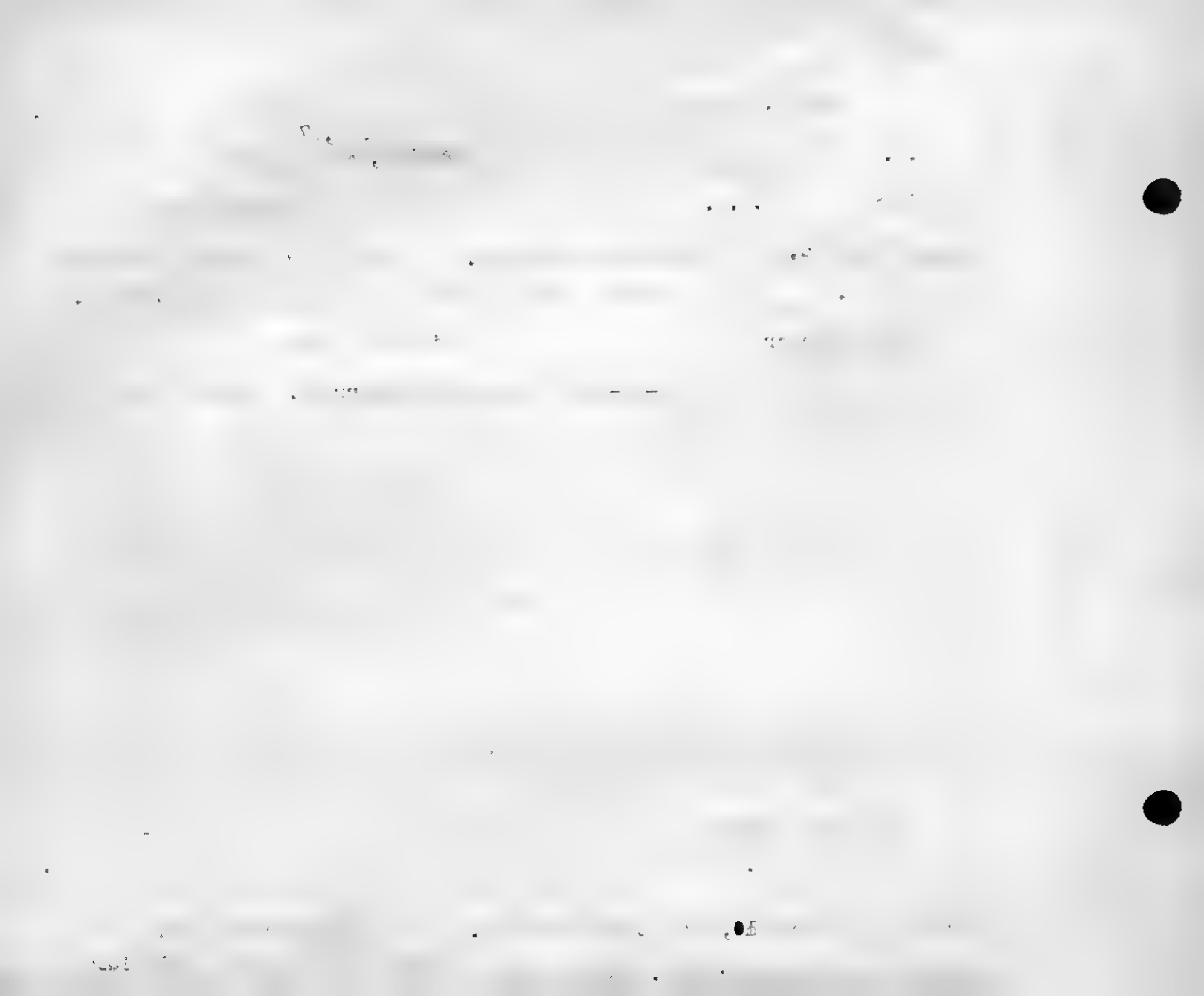
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
04963							04955		
1. DECEASED-NAME (Type or print) Reubin			First Middle Last --- Braudes			2a. DATE OF DEATH 4 Month 4 Day 69 Year			2b. HOUR 10:50 A.M.
3 SEX male		4 RACE white		5. DATE OF BIRTH 12/29/97		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CONTRACTOR PLUMBING & HEATING		12b. KIND OF BUSINESS OR INDUSTRY INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3625 Courtleigh Drive	
14. FATHER'S NAME First Middle Last ABRAHAM BRAUDES			15. MOTHER'S MAIDEN NAME First Middle Last RACHAEL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or unknown) YES		16b. SOCIAL SECURITY NO. (If give war or dates of service) W.W. I M.C. 216-32-6560		17. INFORMANT MRS. PEARL BRAUDES, 3615 COURTLEIGH DRIVE RANDALLSTOWN, MD. 21133					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 517.2 Infective Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY PULMONARY DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE LUNG DISEASE YEARS									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 12 HOURS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 4-4 , 19 69 , to 4-4 , 19 69 , that (I) (we) last saw the deceased alive on 4-4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Angelita A. Topacio		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-4-69			
22d. PHYSICIAN'S NAME (Type) ANGELITA A. TOPACIO		22e. ADDRESS BL 2A1 RANDALLSTOWN MD							
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-6-69		23c. NAME OF CEMETERY OR CREMATORY HAR ZION TIFERETH ISRAEL		23d. LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR DATE APR 9 1969		25b. REGISTRAR'S SIGNATURE William A. Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
Anna M. Brauer								April Month 8 Day 69 Year			7A. M
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER YEAR		IF UNDER 24 HRS
F.M.		White		April 6, 77			92 YRS		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Baltimore		U.S.A.					Baltimore County			Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Owings Mills Md.		9922 Reisterstown Rd.			Buyer for Stewarts			Millery			
13a. USJA. RESIDENCE (Where deceased lived if institution Res dence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. ASIDE CITY L.H. IS?		13e. STREET AND NUMBER			
Md.		Baltimore		Owings Mills		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9922 Reisterstown Rd.			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
Henry Brauer								Elisabeth Peetz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address					
NO		220-44-7111		Miss Helen Knoer Rt. 5 Box 325		21207					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.										5 days	
IMMEDIATE CAUSE (a) Terminal Pneumonia											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										years	
(b) Arteriosclerotic C.V. Disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb. 27, 1969, to April 8, 1969, that (I) (we) lost saw the deceased alive on April 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Martin E. Strobel		4-8-69									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Martin E. Strobel, M.D.		59 Hanover Rd. Reisterstown Md		21136							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		April 22, 69		Loudon Park Cem.		Baltimore Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Loring Byers		8728 Liberty Rd. Randallstown		APR 10 1969		Chas. A. Judge					



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15, 4)
45M - 1/69

1. DECEASED NAME (Type or print)		First Mitchell		Middle Wayne		Last BRITTINGHAM		2a. DATE OF DEATH Month 4 Day 21 Year 69		2b. HOUR 4:15 A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5/20/64		6. AGE (In years last birthday) 4		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY ---					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Delmar		13d. HSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 16 West East Street			
14. FATHER'S NAME First Chester		Middle Wayne		Last Brittingham		15. MOTHER'S MAIDEN NAME First Linda		Middle Mae		Last KUNDE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) no		16b. SOCIAL SECURITY NO ----		17. INFORMANT Address Rosewood Records, Owings Mills, Md. 21117							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
4862 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Microcephaly with spasticity. Right hemiplegia and right facial palsy.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/17/ , 19 69 , to 4/21/ , 19 69 , that (I) (we) last saw the deceased alive on 4/21/ , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Orlando C. Ramos</i>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/21/69					
22d. PHYSICIAN'S NAME (Type) Orlando C. Ramos, M.D.		22e. ADDRESS Rosewood State Hospital, Owings Mills, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/24/69		23c. NAME OF CEMETERY OR CREMATORY St. Ann's		23d. LOCATION (City or Town) (County) (State) Delmar, Wicomico, Md.					
24. FUNERAL DIRECTOR <i>M. S. Manuel</i>		ADDRESS Delmar, Md.		25a. REC'D BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE <i>William S. Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04966

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04958

1. DECEASED-NAME (Type or print) JAMES STUART BROWN		2a. DATE OF DEATH Month APRIL Day 1 Year 1969		2b. HOUR 1:30 A.M.
3 SEX M MALE	4. RACE W	5. DATE OF BIRTH 8/8/1914	6. AGE (In years last birthday) 54	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Balto., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8201 Pleasant Plains Rd.	12a. USUAL OCCUPATION (Kind of work done dur no most of working life, even if rehired.) Bar Tender	12b. KIND OF BUSINESS OR INDUSTRY Amble Inn	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Towson	13d. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>	13e. STREET AND NUMBER 8201 Pleasant Plains Rd
14. FATHER'S NAME First Harry Middle Brown Last Brown	15. MOTHER'S MAIDEN NAME First Frances Middle Mansfield Last Mansfield			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII	16b. SOCIAL SECURITY NO. 213-01-6354	17. INFORMANT Address Mrs. Helen D. Brown (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUCOC'S CIRRHOSIS 5710 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CARCINOMA OF PHARYNX				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from JUNE , 1968, to APRIL 1 , 1969, that (I) (we) last saw the deceased alive on MARCH 30 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Samuel O. Malsky MD		22c. DATE SIGNED April 1 1969		
22d. PHYSICIAN'S NAME (Type) SAMUEL O. MALSKEY		22e. ADDRESS 8523 LOCHRAVEN BLVD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/4/1969	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. RECEIVED BY REGISTRAR DATE APR 2 1969	25b. REGISTRAR'S SIGNATURE Francis Judge	

TO HOSPITAL OR ... TENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04967

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04959

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
WIONA		BALLARD	BRYAN	APRIL 19, 1969		8:10a		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
FEMALE	NEGRO		FEBRUARY 4, 1924		45 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		USA				BALTIMORE Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON 21204		ST. JOSEPH HOSPITAL						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY L-H-TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND		#21613		CAMBRIDGE				805 FAIRMOUNT AVENUE
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
ANDREW		MADDOX		BEATRICE BALLARD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT				
NO				Address ROGER BRYAN, CAMBRIDGE, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Terminal carcinomatosis, Primary in pancreas</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from April 5, 1969 to April 19, 1969, that (X) (we) last saw the deceased alive on April 19, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
Reynaldo Orjuela-Gomez, M.D.		APRIL 19, 1969						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
		7620 York Road, Towson 4, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		4/23/1969		WAUGH CEMETERY		CAMBRIDGE, DORCHESTER MD.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Fidelis C. [Signature]		CAMBRIDGE, MD.		APR 25 1969		[Signature]		

7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

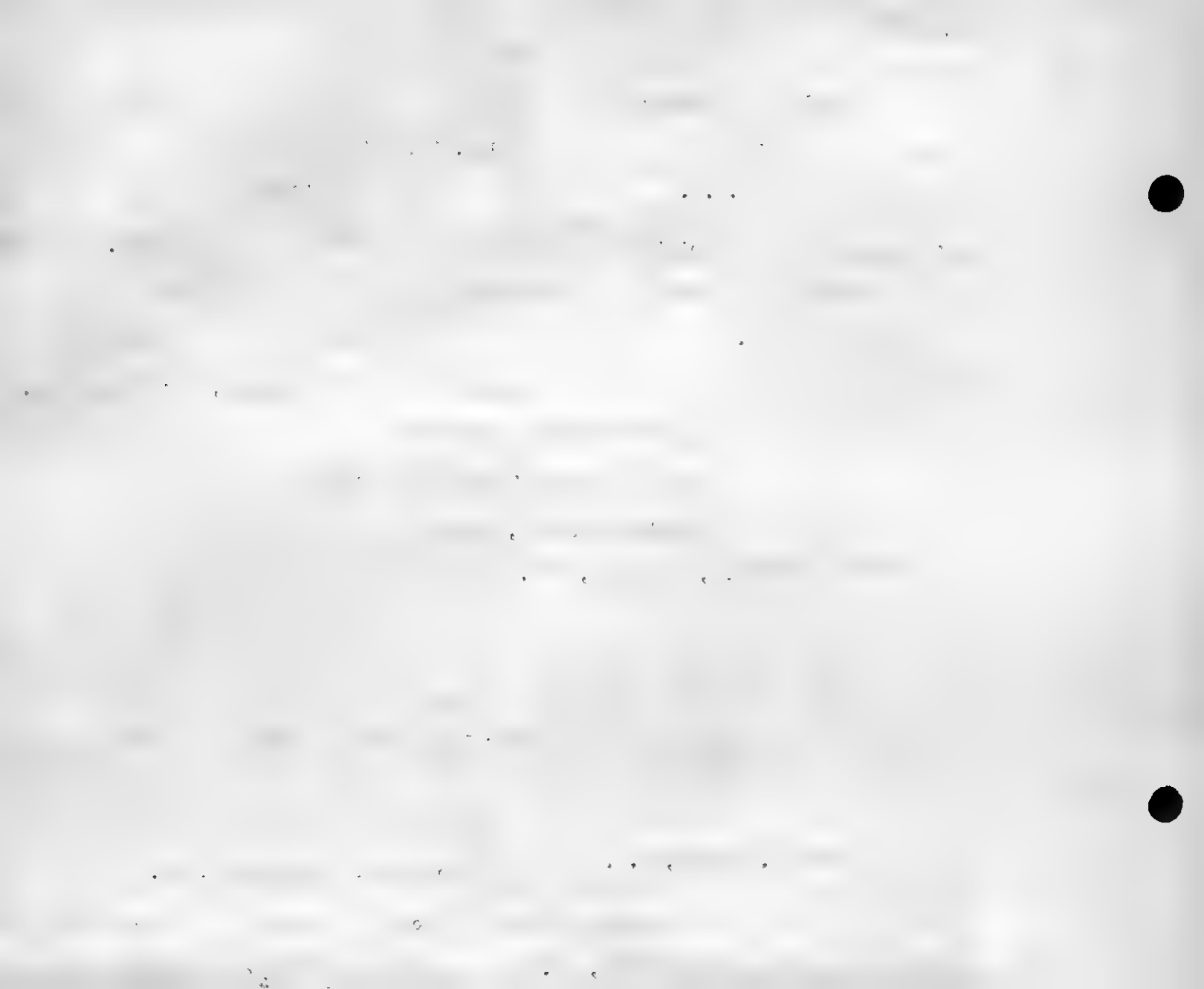
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Mary Catherine Buccheri									Month 4 Day 23 Year 69		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		
Female		Cau.		9-13-22			46 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Boston, Mass.		U.S.A.				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			St. Joseph's Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INS. OR CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore			Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		106 Ardoon Rd. 7620 York Road A/21204	
14. FATHER'S NAME			First			Middle			Last		
Peter Laurino											
15. MOTHER'S MAIDEN NAME			First			Middle			Last		
Josephine Sardella											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			?			Joseph S. Buccheri					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, primary in breast</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION					
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 21, 19 69</u> to <u>April 23, 19 69</u> , that (I) (we) last saw the deceased alive on <u>April 23, 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d) (d.d not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Dr. R. Orquela Gomez						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
						7620 York Rd. Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			4-26-1969			Dulaney Valley Memorial			Cockeysville, Maryland		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Wm. Cook-Brooks Towson 1050 York Road 21204									25b. REGISTRAR'S SIGNATURE		
									f Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS
45M 1189

04969												04961																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												CERTIFICATE OF DEATH																							
1. DECEASED NAME (Type or print)						First Middle Last						2a. DATE OF DEATH						2b. HOUR																	
EDGAR						MONROE						BULL						April 9 1969						2:20 M											
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR				IF UNDER 24 HRS.															
MALE				WHITE				Jan. 23, 1921				48 YRS				MONTHS				DAYS															
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																							
MARYLAND				U.S.A.								BALTIMORE																							
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during normal working life, even if retired)						12b. KIND OF BUSINESS OR INDUSTRY																	
FORT HOWARD						Veterans Administration Hospital						CLERK						SOC. SECURITY																	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS?						13e. STREET AND NUMBER											
MARYLAND						CARROLL						SYKESVILLE						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						149 Carter Road											
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																													
First Middle Last						First Middle Last																													
THOMAS E. BULL						ODA						SINDALL																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT						Address																	
YES						WW-11						218 01 4332						Clinical Rcds, VA Hospital, Fort Howard, Md.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												ACUTE MYOCARDIAL INFARCTION																							
DUE TO, OR AS A CONSEQUENCE OF												CORONARY ARTERY THROMBOSIS, RECENT																							
DUE TO, OR AS A CONSEQUENCE OF												BRONCHOPNEUMONIA, RECENT																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
MULTIPLE SCLEROSIS, CLINICAL, OLD.																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				YES																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																											
				HOUR A.M. Month Day Year P.M. 19																															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)				21f. LOCATION				Street or R.F.D. No				City or Town																			
22a. I certify that (X) (this hospital) attended the deceased from April 8, 1969, to April 9, 1969, that (X) (we) last saw the deceased alive on April 9, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death.																																			
22b. SIGNATURE												22c. DATE SIGNED																							
ERHARD I. BUNYOR, M.D.												4/9/69																							
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS																							
												VA Hospital, Fort Howard, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)				(County)																			
Burial				4-12-69				Hereford Baptist Cemetery				Hereford				Carroll Maryland																			
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE											
HAIGHT FUNERAL HOME												APR 14 1969												Charles Judge											
ELDERSBURG, MD.																																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04970

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04962

1 DECEASED NAME (Type or print) Harvey Richard Burgoon			2a. DATE OF DEATH Month April Day 2 Year 1969			2b. HOUR 1:12 ^P	
3 SEX Male		4 RACE White		5 DATE OF BIRTH May 8, 1898		6 AGE (in years lost birthday) 70 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY L.W. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 2716 Berwick Ave. # 21234		14 FATHER'S NAME First Harvey Middle m Last Burgoon		15 MOTHER'S MAIDEN NAME First Emma Middle Last Frock			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO 216-09-0533A		17. INFORMANT Mrs Lorene M Burgoon		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1 DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cerebral hemorrhage							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.							
(b) Arteriosclerotic Cardiovascular Disease							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that he (this hospital) attended the deceased from April 2 , 1969, to April 2 , 1969, that he (we) last saw the deceased alive on April 2 , 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Beatriz Dizon</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED April 2, 1969	
22d. PHYSICIAN'S NAME (Type) Beatriz Dizon, M.D.				22e. ADDRESS 7620 York Rd. Baltimore, Md. 21204			
23a BURIAL, CREMATION (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		4/5/69		Moreland Memorial Park		Baltimore, Maryland	
24 FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland				25a REC'D BY REGISTRAR DATE APR 3 1969		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04971		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04960	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print) LAST BURK		Middle Carl		FIRST ANDREW		2a. DATE OF DEATH Month Day Year APRIL 5, 1969	
3. SEX MALE		4 RACE WHITE		5. DATE OF BIRTH AUGUST 21, 1887		6 AGE (In years last birthday) 81 YRS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10 CITY OR TOWN OF DEATH TOWSON 21204		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Gardner-retired		12b. KIND OF BUSINESS OR INDUSTRY State	
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE MARYLAND		13b CITY OR TOWN BALTIMORE		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 909 Radcliffe Road-21204	
14 FATHER'S NAME First Middle Last Andrew Carl Burk				15 MOTHER'S MAIDEN NAME First Middle Last Catherine Trapp			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If none, give war or dates of service) No None		16b SOCIAL SECURITY NO 217-09-0351A		17 INFORMANT Address Family records			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into lungs DUE TO, OR AS A CONSEQUENCE OF pulmonary embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that he (this hospital) attended the deceased from March 6, 1969 to April 5, 1969 , that he (we) lost saw the deceased alive on April 5, 1969 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, he (we) did observe view the body after death.							
22b SIGNATURE <i>Samuel C. H. Lee</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED April 5, 1969	
22d PHYSICIAN'S NAME (Type) Samuel C. H. Lee, M.D.				22e ADDRESS 7620 York Road, Towson 4, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE April 8, 1969		23c NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City or Town) (County) (State) Blenheim, Balto. Co., Md.	
24 FUNERAL DIRECTOR John Burns Sons		ADDRESS Towson		25a REC'D BY REGISTRAR DATE APR 10 1969		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First GEORGE		Middle A.		Last BURLEY		2a. DATE OF DEATH Month 4 Day 29 Year 69		2b. HOUR 4:00AM
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH 5/8/98		6. AGE (In years last birthday) 70 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE COUNTY,		Md		
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) VET. ADM. HOSPITAL		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) LABORER		12b. KIND OF BUSINESS OR INDUSTRY CHEMICAL PLANT				
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY 136		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2807 BRIGHTON STREET		
14. FATHER'S NAME First JOHN		Middle BURLEY		Last BURLEY		15. MOTHER'S MAIDEN NAME First SARAH		Middle QUEEN		Last QUEEN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give branch and dates of service) YES		16b. SOCIAL SECURITY NO 218 07 18 64		17. INFORMANT VAH FORT HOWARD, MD. CLINICAL RECORDS		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRA ABDOMINAL CANCER WITH METASTASIS										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1750										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) GENERAL DEBILITY										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/25/69 , 19____, to 4/29/69 , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/29/69 , 19____, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE George C. McElpatrick, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/29/69		
22d. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.						22e. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE 5-5-69		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.				
24. FUNERAL DIRECTOR V.L. Bailey		ADDRESS KELSON FUNERAL HOME		25a. BY REGISTRATION MAY 2, 1969		25b. BY REGISTRATION MAY 2, 1969				
				1318 Calhoun St. Baltimore, Md.						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
04973		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						04965				
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR p:20 M	
Blanche			V.		Burrs				April 1, 1969			
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
female		white		March 13, 1913			56		YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						
Md.		U. S.				Baltimore						
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Catonsville				SPRING GROVE STATE HOSP.				housewife				
13a USUAL RESIDENCE (Where deceased lived, if institution or admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS-DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.			Balto.		White Marsh				Box 52			
14 FATHER'S NAME				First		Middle		Last		15 MOTHER'S MAIDEN NAME		
George Hoffman										Ginny		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT							
No			220-30-5326		Records: SPRING GROVE STATE HOSPITAL							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF <u>advanced arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>hypertension</u> (b) <u>hypertension</u> (c) <u>hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>old CHD & B. pleuropneumonia</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. co. examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a I certify that he (this hospital) attended the deceased from <u>March 26, 1969</u> , to <u>April 1, 1969</u> , that he (we) last saw the deceased alive on <u>April 1, 1969</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did not view the body after death												
22b SIGNATURE			22c DATE SIGNED			22d. PHYSICIAN'S NAME (Type)						
<u>Miguel Heredia, M.D.</u>			4-1-69			Miguel Heredia, M.D.						
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)		(County) (State)		
Burial			4/5/69		Hollywood Cemetery			Baltimore, Md.				
24 FUNERAL DIRECTOR			25a RECD BY REGISTRAR			25b REGISTRAR'S SIGNATURE						
Lupsha Funeral Home			APR 8 1969			Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04974

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04966

1. DECEASED-NAME (Type or print) <i>Elizabeth D. Cadell</i>			2a. DATE OF DEATH April <i>9</i> , 1969 Year <i>1969</i>			2b. HOUR <i>10:30</i> A.M.			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov. 10, 1891</i>		6. AGE (In years lost birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Catonsville, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore County, Md.</i>			
10. CITY OR TOWN OF DEATH <i>Catonsville, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>118 Smithwood Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore-Catons-</i>		13c. CITY OR TOWN <i>Catonsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>118 Smithwood Avenue</i>	
14. FATHER'S NAME First Middle Last <i>Frederick R. Diehlmann</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Katherine Bechman</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-46-9363</i>		17. INFORMANT Address <i>W. E. Cadell -203 Hilton Ave. -21228</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> <i>4/17/69</i> DUE TO, OR AS A CONSEQUENCE OF <i>with chronic failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>3-11</i> , 1969, to <i>4-4</i> , 1969, that (I) (we) last saw the deceased alive on <i>4-3</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John A. Nesbitt, Jr.</i>		22c. DATE SIGNED <i>4-10-69</i>		22d. PHYSICIAN'S NAME (Type) <i>John A. Nesbitt, Jr., M.D.</i>		22e. ADDRESS <i>1009 Frederick Road, 21228</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/11/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cem Salem Luthern Church</i>		23d. LOCATION (City or Town) (County) (State) <i>Catonsville, Balto., Md.</i>			
24. FUNERAL DIRECTOR <i>Stirling Funeral Estate</i> <i>736 Edmondson Ave.</i> <i>Catonsville, Md. 21228</i>		25a. RECEIVED BY REGISTRAR <i>APR 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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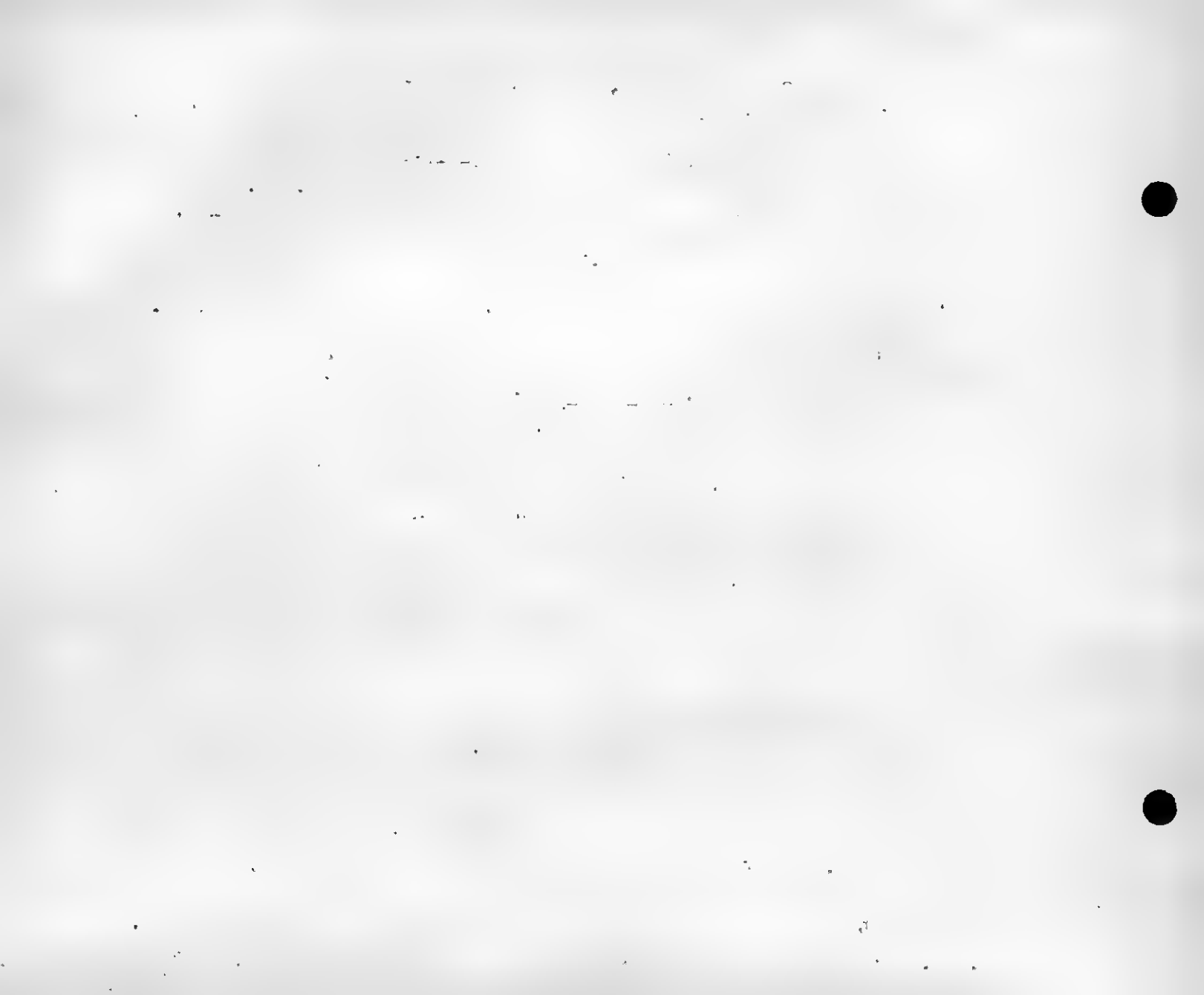
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04975									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First George	Middle E.	Last Caltrider	2a. DATE OF DEATH April Month 10 Day 69 Year			2b. HOUR 6 P. M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 1, 1902		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Balto. City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Glyndon		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2 Chatsworth Ave.			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Iron Worker			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Glyndon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2 Chatsworth Ave.	
14. FATHER'S NAME First Middle Last John Caltrider			15. MOTHER'S MAIDEN NAME First Middle Last Mary Ford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or (unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-01-5079		17. INFORMANT Mrs. Edna M. Caltrider			Address Glyndon, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <u>C.V. and</u> (b) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u> <u>1 yr</u> <u>10 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-1-69</u> to <u>4-10-69</u> , that (I) (we) last saw the deceased alive on <u>4-7-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James B. Saffell</u>		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-10-69</u>			
22d. PHYSICIAN NAME (Type) <u>James B. Saffell</u>		22a. ADDRESS <u>Reisterstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 14, 69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City or Town) <u>Baltimore, Md.</u>		(County) (State)	
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons Reisterstown, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 14 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04976									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First <u>SUSAN</u> Middle <u>Campbell</u> Last <u>CAMPBELL</u>		2a. DATE OF DEATH			2b. HOUR		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. MONTH DAY YEAR	
Female		white		8-2-1890		78 YRS.		11:50 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		US				Balto.		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Stella Maris Hospice		Ho sekeeper					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Balto.		City		Balto.		YES		34 York Ct.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Thomas Campbell		Virginia Dunn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		120 30 0034 A		T.D. CAMPBELL STELLA MARIS HOSPICE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Diphtheria</u>									Weeks
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of pancreas</u>									Months
DUE TO, OR AS A CONSEQUENCE OF (c) <u>intracranial metastases</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M.							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>68</u> , to <u>APR</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>APR. 7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>[Signature]</u>		4/8/69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
J. DAVID NAGEL		STELLA MARIS HOSPICE							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4/10/69		NEW CATHEDRAL		BALTIMORE MD.			
24. FUNERAL DIRECTOR		25a. DEED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
H. W. NEARS & SON 805 N. CALVERT ST		APR 11 1969		<u>[Signature]</u>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04977

04969

1 DECEASED-NAME (Type or print)		First LOUIS	Middle DEWEY	Last CAMPEGGI	2a. DATE OF DEATH APRIL Month 20 Day 1969 Year		2b. HOUR 10:30AM
3 SEX Male	4 RACE White		5 DATE OF BIRTH May 6, 1898		6 AGE (In years lost birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md.		
10 CITY OR TOWN OF DEATH Fort Howard		NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Barber		12b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY, Y.M.S.? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME Frank		15 MOTHER'S MAIDEN NAME Elizabeth		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WW I			
16b SOCIAL SECURITY NO 212 14 2730		17 INFORMANT Clin. Rec. VAH, Fort Howard, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNKNOWN
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or RFD No City or Town County State			
22a. I certify that XX (this hospital) attended the deceased from April 18, 1969 to April 20, 1969 , that he (we) last saw the deceased alive on April 20, 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) not view the body after death.							
22b SIGNATURE <i>Elsa M. Goris</i>				22c DATE SIGNED 4/20/69		22d. PHYSICIAN'S NAME (Type) ELSA M. GORIS, M.D.	
22e ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE April 24, 1969		23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Leonard J. Rack, Inc.		ADDRESS 5305 Harford Road Baltimore, Maryland		25a. REC'D BY REGISTRAR APR 21 1969		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

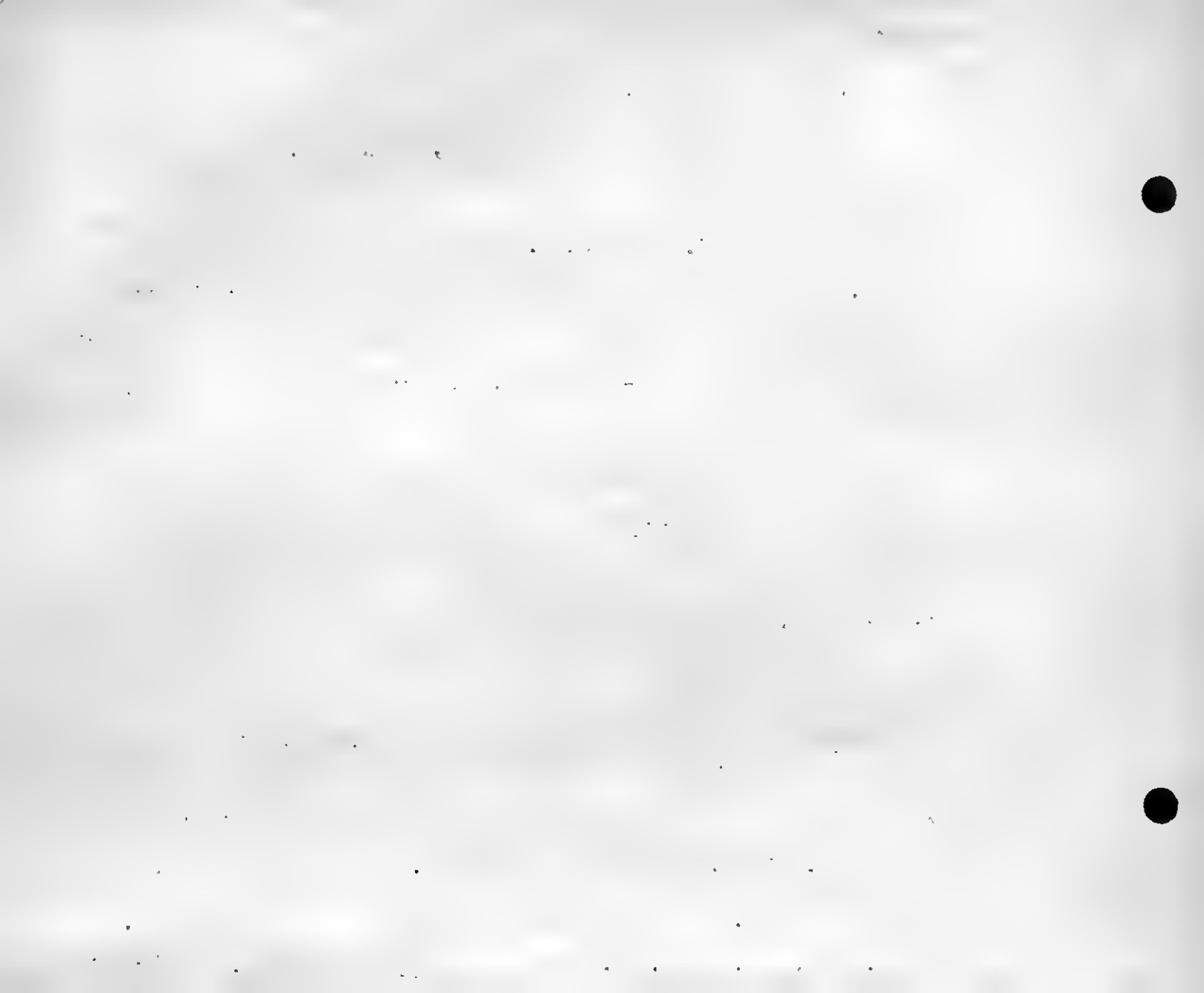
04978

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04970

1. DECEASED NAME (Type or print) First Middle Last GAETANA NMN CARLOTTA			2a. DATE OF DEATH APRIL Month 16 Day 69 Year			2b. HOUR 1:40 P.M.	
3 SEX FEMALE		4. RACE White		5. DATE OF BIRTH May 20, 1895		6. AGE (In years last birthday) 73 YRS.	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? Italy		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER 2912 Grindon Avenue							
14. FATHER'S NAME First Middle Last Joseph Determini			15. MOTHER'S MAIDEN NAME First Middle Last Mary Determini				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. 212-40-5885		17. INFORMANT Mrs. Mary McClure		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line far (a) (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 1517 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA Candians, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PANCREATIC PRIMARY CARCINOMA							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH L 8 L 1MO MO TO A YR
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 4-10-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLORATORY LAPAROTOMY CA LIVER METASTATIC		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-3 , 19 69 to 4-16 , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 16 , 19 69 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard C. Smith MD</i>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-16-69	
22d. PHYSICIAN'S NAME (Type) DR. RICHARD SMITH MD				22e. ADDRESS 6701 N. CHARLES ST. BALTO. MD 21204			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/21/69.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21211				25a. REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>04979</div> <div>CERTIFICATE OF DEATH</div> <div>04971</div>									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Joseph D. Catalano						Month 4 Day 17 Year 69			7:30 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		Cau.		8-12-12		56 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore						Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Baltimore			St. Joseph's Hospital			Machine Operator			Tool
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Sparks	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		26 Belclare Circle	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Dominic Catalano			Antonia Vitale						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
Yes			216-09-7178		Mrs. Alicia Catalano 26 Belclare Circle, Sparks, Md.				
18. CAUSE OF DEATH (Enter any one cause per line for (a) (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Generalized Sepsis									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b) Carcinoma of Colon									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION		City or Town County State		
					Street or R.F.D. No.				
22a. I certify that (H) (this hospital) attended the deceased from April 16, 1969, to April 17, 1969, that (H) (we) last saw the deceased alive on April 17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
[Signature]		April 18, 1969			Dr. Samuel C.H. Lee				
		DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
		22e. ADDRESS							
		7620 York Road, Towson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-21-1969		Sacred Heart Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. Cook-Brooks Towson 1050 York Rd. 21204						APR 21 1969		[Signature]	



1
1
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04980

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04972

1 DECEASED NAME (Type or print) First Middle Last Bertie Henderson Chaney			2a DATE OF DEATH Month Day Year April 24 69			2b HOUR M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH Feb. 11, 1886		6. AGE (In years last birthday) 83 YRS.	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10 CITY OR TOWN OF DEATH Ruxton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2006 Indian Head Rd.		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Retired Homemaker		12b KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Ruxton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2006 Indian Head Rd.		14 FATHER'S NAME First Middle Last Gaither W. Henderson		15. MOTHER'S MAIDEN NAME First Middle Last Allie Burgess			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 213-40-8442		17 INFORMANT Mrs. Wm. H. Marshall, Jr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1-17-69							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January 6, 1969, to April 24, 1969, that (I) (we) lost the deceased alive on April 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald O. Wood				22c. DATE SIGNED 4-25-69		22d. PHYSICIAN'S NAME (Type) Donald O. Wood	
22e. ADDRESS York Rd. & Greenmeadow Dr.				22f. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-69		23c. NAME OF CEMETERY OR CREMATORY Smithville		23d. LOCATION (City or Town) (County) (State) Dunkirk Md.	
24. FUNERAL DIRECTOR H. W. Jenkins Sons Co.				25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE Charles Young	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
04981						04973											
1 DECEASED NAME (Type or print)						First		Middle		Last		2a. DATE OF DEATH		2b. HOUR			
IDA						E.		CLARK		April 26, 1969		9:30 PM					
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (in years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White			April 26, 1889			80 YRS.			MONTHS		DAYS			
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH								
Baltimore			U S A						Baltimore			Md					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY					
Catonsville				Shangrila N/H				Housewife				Own Home					
13a USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN		13d RESIDENCY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER					
Maryland				Anne Arundel				Pasadena				Box 240-A Long Point					
14. FATHER'S NAME						First		Middle		Last		15. MOTHER'S MAIDEN NAME					
Andrew						F.		Kroupa				Theresa					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)						16b SOCIAL SECURITY NO		17 INFORMANT						Address			
No						None		220-30-2404		Mrs. C. Wilmer Lurz - Daughter						Same as #	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u>												Instantaneous					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>4/1/69</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>												9 months					
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>																	
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f LOCATION Street or RFD No		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-12-1966</u> , to <u>4-26-1969</u> , that (I) (we) last saw the deceased alive on <u>4-26-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE <u>Cesar Valle Cervero</u>						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED							
22d PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>						22e. ADDRESS <u>8629 Liberty Rd</u>											
23a BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				4/29/69		Holy Redeemer Cemetery				Baltimore, Maryland							
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Singleton Funeral Home						Glen Burnie, Maryland		APR 29 1969		<u>Charles Judge</u>							

FOR STATE
HEALTH DEPT.

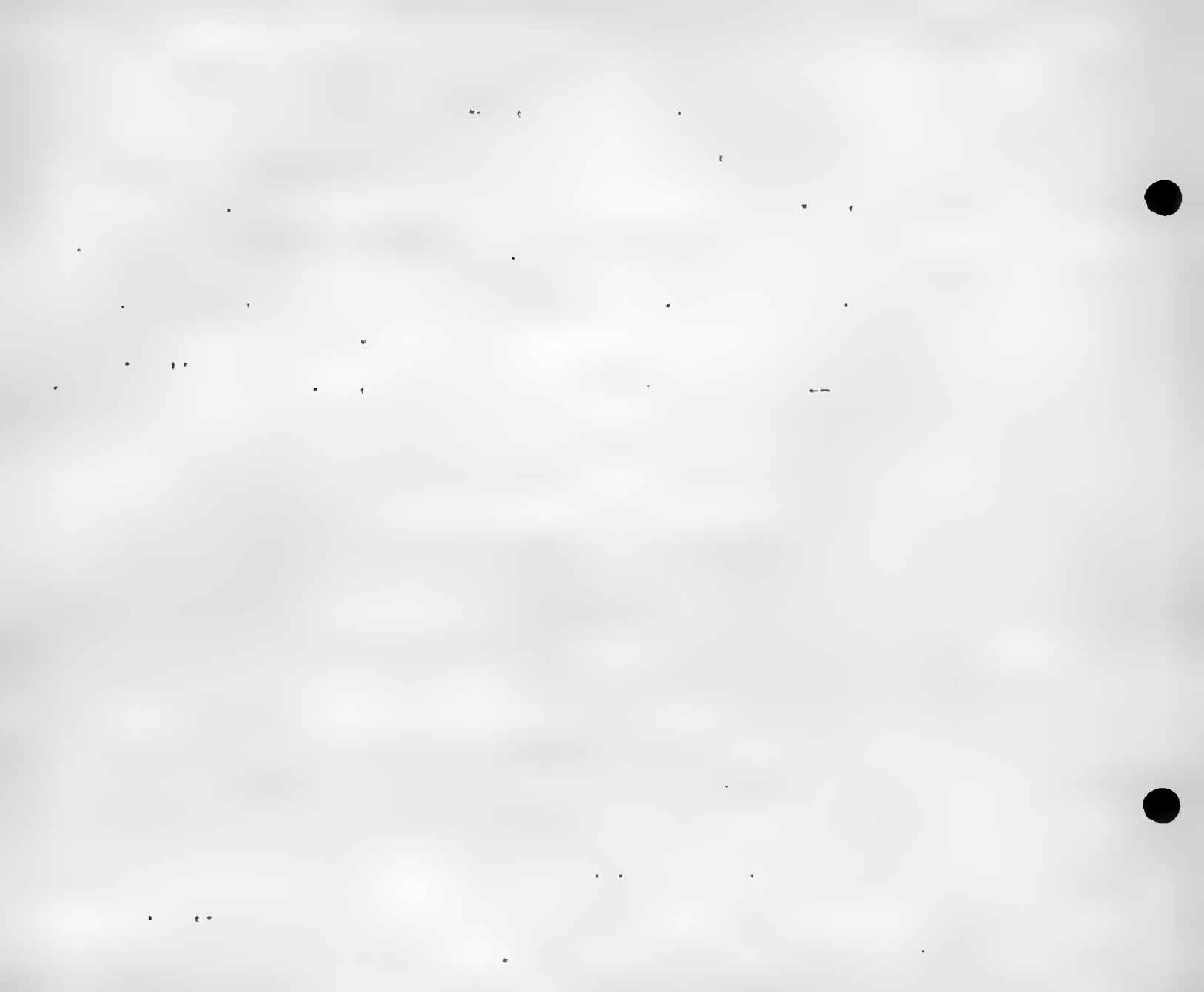
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04982

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04974

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
RAYMOND N. CLARKE, SR.						4 19 1969			4:20 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR		
Male	White	April 7, 1912	57 YRS			April 19 1969			4:20 AM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore, Md.		USA				Balto.			Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Dundalk			2000 LarkHall Rd.			Route Salesman			Milk Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Balto.			Dundalk			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		
Harvey Clarke			Gerturde F. Disney			No			213 10 7368		
17. INFORMANT			18. ADDRESS			19. CITY OR TOWN			20. STATE		
Raymond Clarke, Jr. 912 "B" Ashbridge Dr.			Balto., Md. 21221								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> PARTIAL			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 4/19/69			
Edward F. Wilson, M.D.				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Burial		4/25/69		Parkwood Cemetery		Baltimore Co., Md.		APR 25 1969		John A. Judge	
24. FUNERAL DIRECTOR				ADDRESS				25c. REGISTRAR'S SIGNATURE			
Brzezinski Funeral Home				1407 Eastern Ave.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, including funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
049883					04975				
1 DECEASED-NAME (Type or print)					2a DATE OF DEATH				
First Middle Last					Month Day Year				
Bennett Bussey Cockey					4/ 4/ 69				
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7b. HOUR	
male		white		May 21, 1901		67		3:50 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U. S.				Baltimore			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Catonsville		SPRING GROVE STATE HOSP.		Lawyer		General Law			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER	
Md.		Balto.		Cockeysville				Beaver Dam Road	
14. FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last				
Joshua F. Cockey III					Anna Bussey				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT Address					
		218-10-8036		Records & SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, lung abscess.</u>									
485X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>March 26, 1968</u> , to <u>April 4, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 4, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. SHEETS, MD</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>April 4, 1969</u>		
22d. PHYSICIAN'S NAME (Type) <u>R. SHEETS, MD</u>					22e. ADDRESS <u>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</u>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>April 7, 1969</u>		<u>Shenwood Church Cemetery</u>		<u>Cockeysville, Maryland</u>			
24 FUNERAL DIRECTOR ADDRESS <u>John Burns' Sons, Towson, Maryland</u>					25a. RECEIVED BY REGISTRAR DATE <u>APR 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
04984			Nicholas Joseph Colantonio			4 Month 21 Day 69 Year			9am M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years less birthday)		IF UNDER 1 YEAR MONTHS DAYS
Male		White		8-9-10			38 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Penna		U.S.					Baltimore County Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last working year, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Randallstown			Balt. Co. Gen. Hospital			BRICKLAYER			BUILDING
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER
Md			BALTIMORE			YES			21215
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Frank PAUL Colantonio			MARIA Amabile Basciano						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
NO			217 07 6863			Baltimore County General Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									5 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral infarction</u>									6 wks
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Occlusion of int. carotid artery</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cronio cerebral trauma</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR AM Month Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			10 PM 3 6 1969			Poss. fall -			
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
			construction site			Unknown.			
22a. I certify that (I) (this hospital) attended the deceased from 3/6/69, 1969, to 4/21, 1969, that (we) lost saw the deceased alive on 4/20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
I.H. WEINER			4/23/69						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
I.H. WEINER			1010 ST PAUL ST						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
BURIAL			25 APR 69			Holy Redeemer Cemetery			Baltimore, Maryland
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
Lemon Funeral Home			4611 Heights			APR 28 1969			Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

049885		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04977	
Item 11 Film 11 4/16/69 kk							
1. DECEASED-NAME (Type or print) George LeRoy Coleman Sr.			First Middle Last			2a. DATE OF DEATH Month April Day 6 , 1969 Year	
3. SEX Male.		4. RACE White.		5. DATE OF BIRTH Sept 13, 1909		6. AGE (In years last birthday) 59 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Md.	
10. CITY OR TOWN OF DEATH Towson.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3 Dellcrest Garth		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Reg. Oper. Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Truck Rental.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Towson.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 3 Dellcrest Garth.		14. FATHER'S NAME First Middle Last ?		15. MOTHER'S MAIDEN NAME First Middle Last ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16b. SOCIAL SECURITY NO. 192-10-8698		17. INFORMANT Address Margaret L. Coleman. 3 Dellcrest Garth.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death Myocardial Infarction. 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic subacute coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1966 to April 1969 , that (I) (we) last saw the deceased alive on Feb 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Francis T. Daly, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/8/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 11 E. Chase Street					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 9, 1969		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gardens		23d. LOCATION (City or Town) (County) (State) Balto. Co.	
24. FUNERAL DIRECTOR Paul E. Chenoweth Jr.		ADDRESS 3615 Chestnut Ave.		25a. REC'D BY REGISTRAR DATE APR 10 1969		25b. REGISTRAR'S SIGNATURE William R. Judge	

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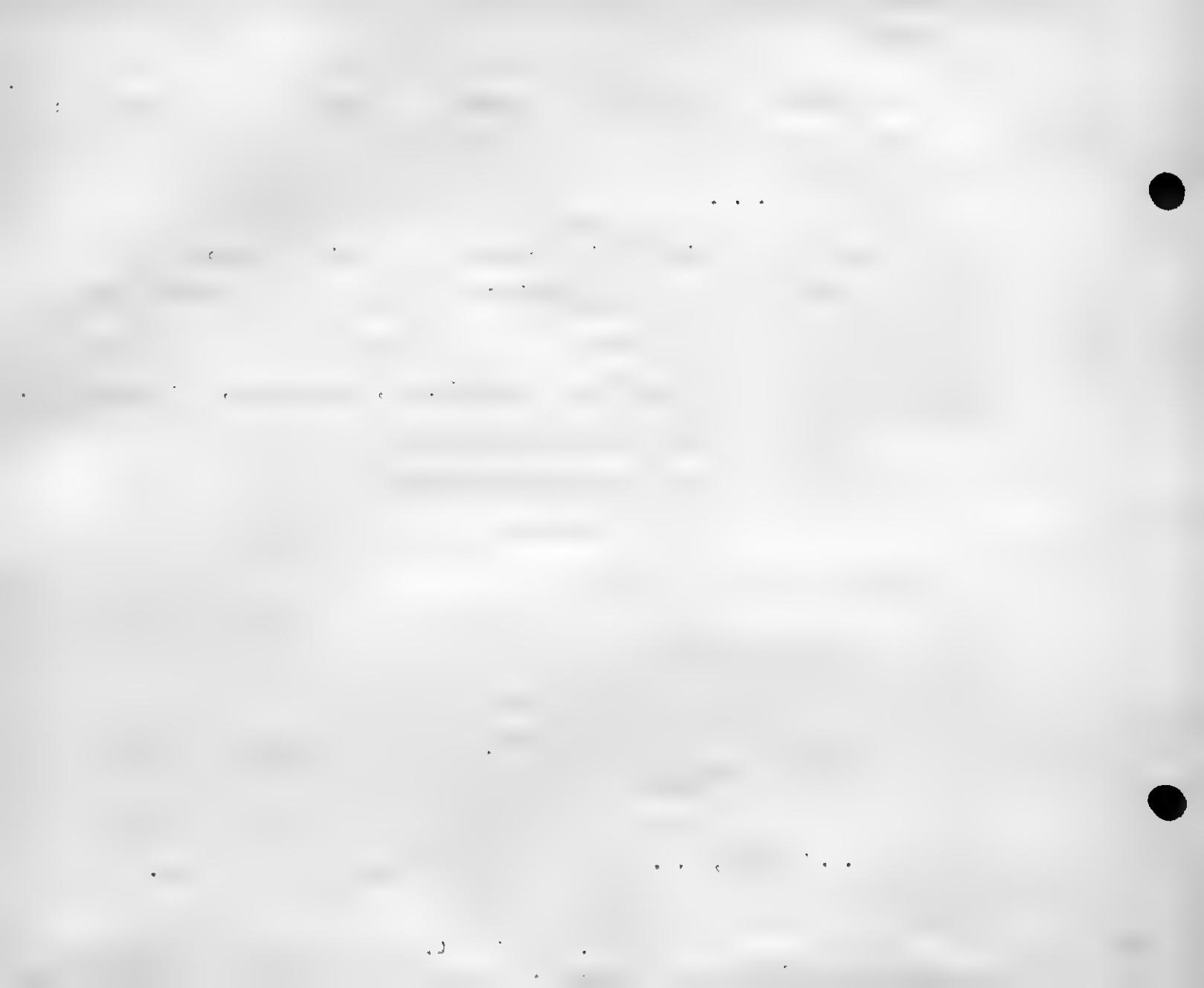
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04986		CERTIFICATE OF DEATH						04978	
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ARTHUR BERNARD COMBS						April 14 1969			7:25 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years b rthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		9/12/1894		74 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Fort Howard			Veterans Administration Hospital			Elevator Operator			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, APTS?		13e. STREET AND NUMBER
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5231 Denmore Avenue
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William - - - Combs			Emma - - - Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
Yes			WW-1		213 05 8218 Clinical Rcds, VA Hospital, Fort Howard, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOLE PHROSCLEROSIS									
509 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) GENERALIZED ARTERIOSCLEROSIS									
DUE TO, OR AS A CONSEQUENCE OF									
(c) DIABETES MELLITUS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
ARTERIOSCLEROTIC HEART DISEASE									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION		City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 25, 19 69, to April 14 19 69, that (I/we) lost saw the deceased alive on April 14 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
J.D. Talbert, M.D.								4/14/69	
22d. PHYSICIAN'S NAME (Type) J.D. TALBERT, M.D.								22e. ADDRESS	
								VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 18 / 69		Baltimore National		Baltimore, Maryland			
24. FUNERAL DIRECTOR			25a. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
ELLIOTT FUNERAL HOME			1129 N. Caroline St. Balto, Md.			APR 21 1969			



1
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04987	04973
1. DECEASED-NAME (Type or print)			First Oliver		Middle Charles		Last Conn		2a. DATE OF DEATH Month 4 Day 24 Year 69		2b. HOUR 9:20 AM
3 SEX Male		4 RACE White		5. DATE OF BIRTH 7-21-81			6 AGE (In years last birthday) 87 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS
7a BIRTHPLACE (State or foreign country) Baltimore		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore Md				
10 CITY OR TOWN OF DEATH Randallstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BCGH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Steel Worker - Armco Steel			12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Baltimore		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5013 Reisterstown Rd.			
14. FATHER'S NAME John Conn			First Middle Last		15. MOTHER'S MAIDEN NAME Elizabeth Andrea Andrews			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO. 218-03-7732		17 INFORMANT Lillian Elizabeth Conn (Schmidt)			Address 21215		5013 Reisterstown Rd.		
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>D. S. C. V. D.</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natally medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/2/67</u> , 19 <u>67</u> , to <u>4/24/69</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>4/22</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Julius C. Gluck, M.D.</u>						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <u>Julius C. Gluck, M.D.</u>						22e. ADDRESS <u>5356 Reisterstown Road 21215</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 28, 69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>				
24. FUNERAL DIRECTOR <u>Loring Byers Chapel 8728 Liberty Rd. 21133</u>						ADDRESS		25a. REC'D BY REGISTRAR DATE <u>APR 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Young</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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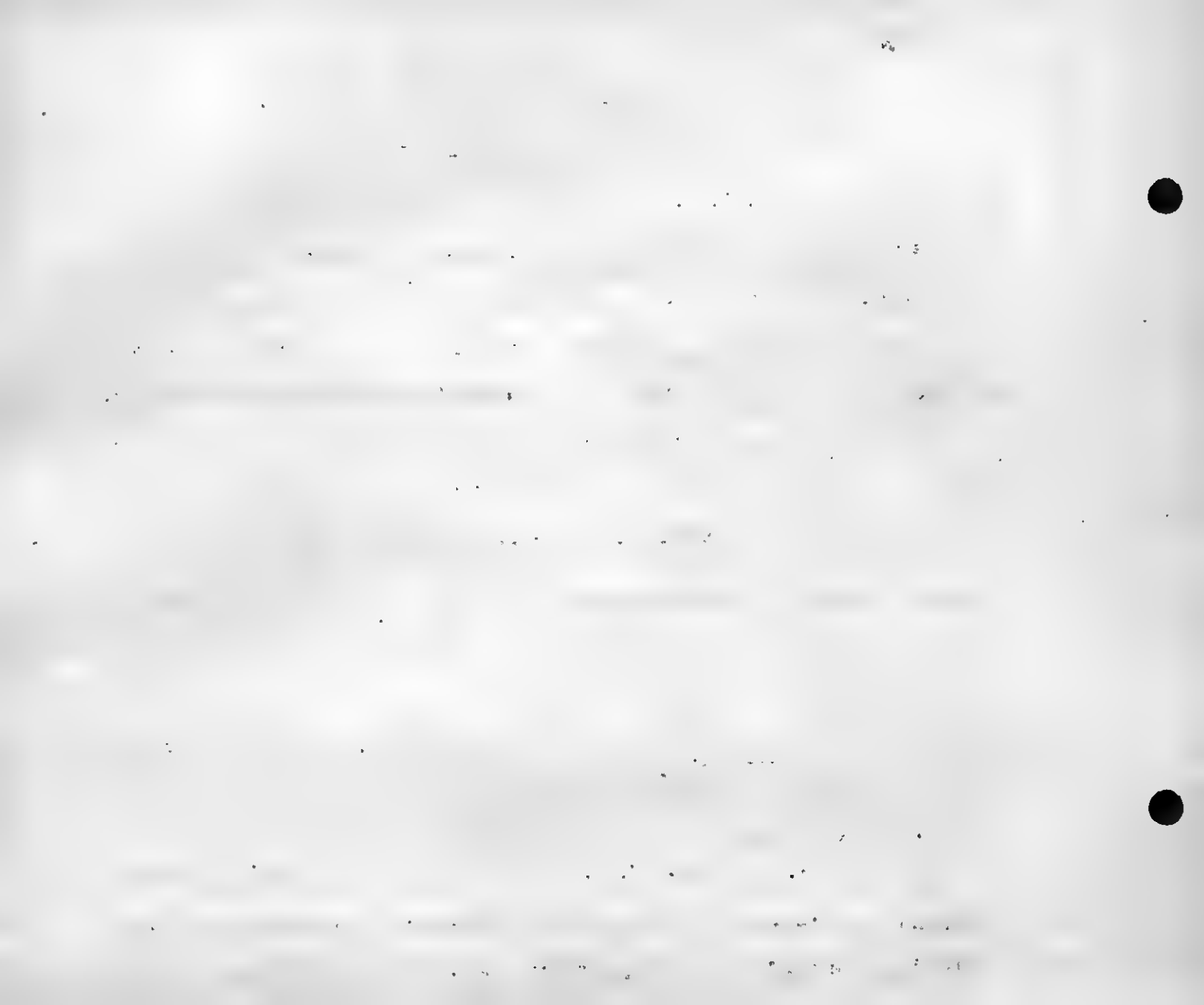
04988

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04980

1 DECEASED-NAME (Type or print) David Robert Conner			2a. DATE OF DEATH Month 4 Day 30 Year 69			2b. HOUR 5:50p	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 7-I-65		6 AGE (In years last birthday) 3 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Owings Mills		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) Dependent		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 203 Marborn Road		14 FATHER'S NAME First Middle Last Gregory Robert Conner		15. MOTHER'S MAIDEN NAME First Middle Last Barbara Lynn Barton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none		17. INFORMANT Address Rosewood's Records Owings Mills Md. 21117			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia 5667 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory arrest, secondary to above							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Hours 4 Hours 10 Minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January 18, 1967, to April 30, 1969, that (I) (we) last saw the deceased alive on April 30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alan S. Greenberg M.D.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-30-69	
22d. PHYSICIAN'S NAME (Type) Alan S. Greenberg M. D.				22e. ADDRESS Rosewood State Hospital Owings Mills, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5-2-69		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Md	
24. FUNERAL DIRECTOR Minnich Funeral Home				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE MAY 5 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

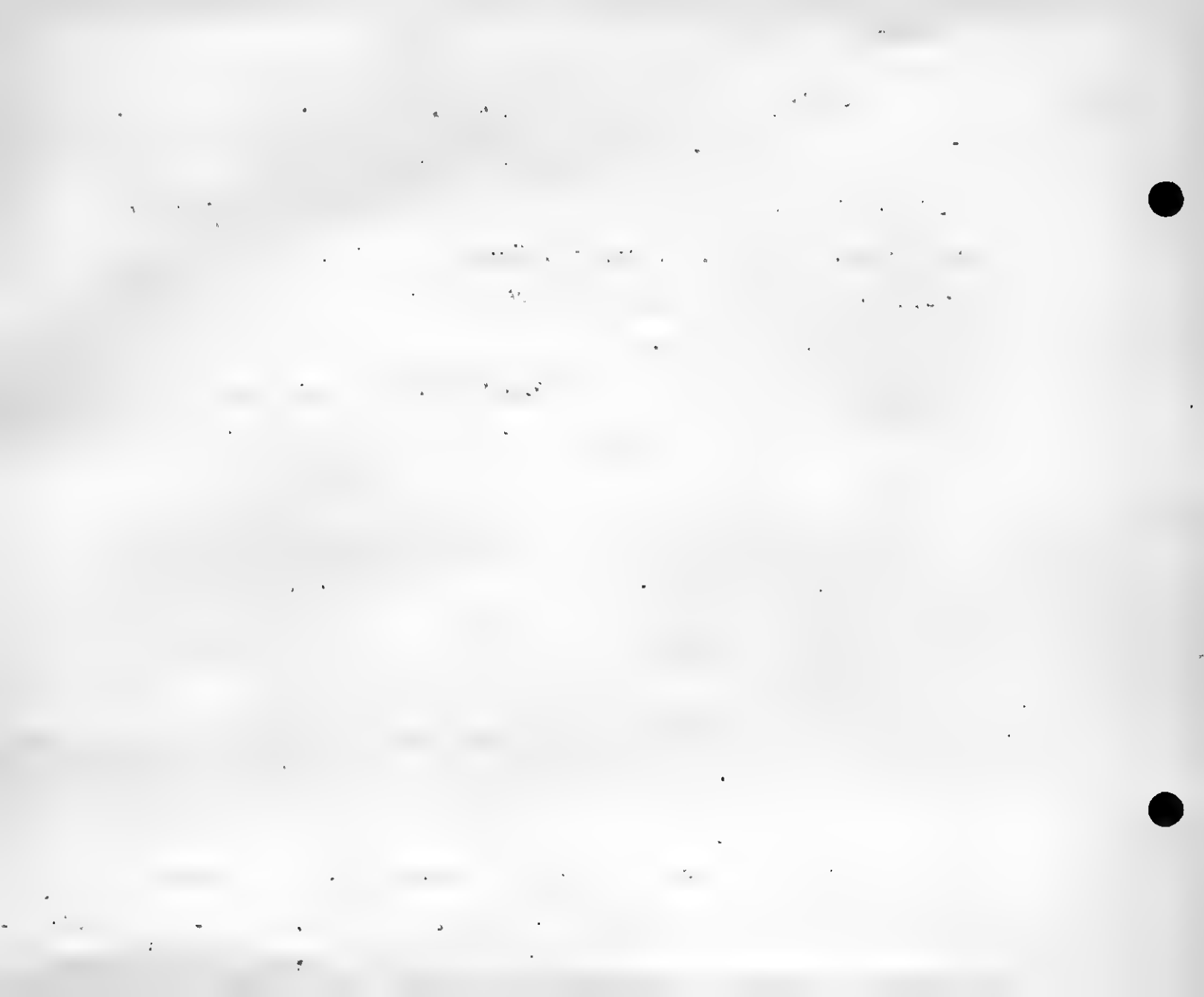
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
ETHEL					CONWAY	APRIL 9, 1969			3:40 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR			
FEMALE		NEGRO		5/5/20		48 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
BALTIMORE		U.S.A.				Baltimore County, Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Mount Wilson			Mt. Wilson St. Hosp.			HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived if admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			—		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		831 W. FAYETTE ST.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JOSEPH			PEACE			?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
						Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 as Advanced Pulmonary Tuberculosis											
011.2 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Hepatic Insufficiency due to Laennec's Cirrhosis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from March 19, 1969, to April 9, 1969, that (I) (we) lost saw the deceased alive on April 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
William Newcomer											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
William Newcomer, M.D.		Mount Wilson, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County		State	
		4/14/69		Balt. National Cem		Baltimore		Maryland			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Charles Judge		DATE APR 11 1969				f Charles Judge					

MEDICAL CERTIFICATION

6/1/69



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
30M REV 1-68

04990

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04982

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) GEORGE RANDALL COOK			2a. DATE OF DEATH April Month 13 Day 1969 Year			2b. HOUR 1:15a M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8-24-11		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		12a. USUAL OCCUPATION (Kind of work done during past year, even if retired) Electric Sales Engineer		12b. KIND OF BUSINESS OR INDUSTRY Machinery			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 563 Woodbine Ave.	
14. FATHER'S NAME First Middle Last George William Cook			15. MOTHER'S MAIDEN NAME First Middle Last Effie Alice Irvin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT Family records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4104 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 29, 1969 , to April 13, 1969 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 13, 1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Beatriz P. Dizon				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-13-69			
22d. PHYSICIAN'S NAME (Type) Beatriz P. Dizon, MD				22e. ADDRESS 7620 York Road, Towson, Md.					
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE April 16, 1969		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.			
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland				25a. REC'D BY REGISTRAR DATE APR 18 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

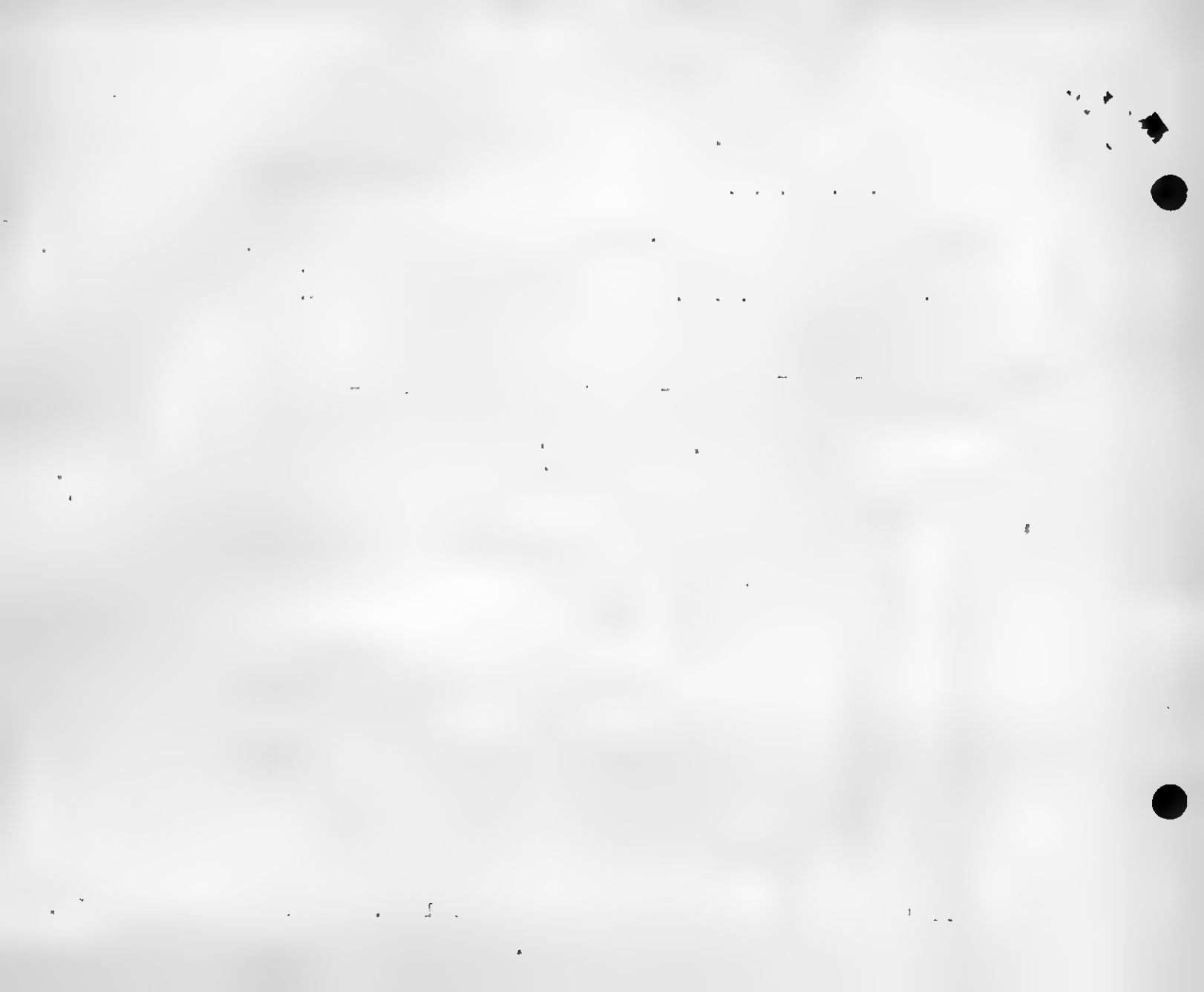
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 4112
5/6/69 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
04991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04988

1. DECEASED NAME (Type or Print) EDWARD JAMES CORKRAN		2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> April Day <input checked="" type="checkbox"/> 30 Year <input checked="" type="checkbox"/> 1969		2b. HOUR M
3 SEX male	4 RACE white	5. DATE OF BIRTH 6 Oct. 1909	6 AGE (In years last birthday) 59 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore
10 CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street & address) St. Joseph		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sheet Metal Worker
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street & address) Maryland		13b. COUNTY A.A. Co.	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME First (Unknown) Middle Corkran Last		15 MOTHER'S MAIDEN NAME First Lena Middle Munchow Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? no (no, or unknown)		16b. SOCIAL SECURITY NO. 215-05-6335		17 INFORMANT Leona Corkran - Wife
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
2a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/3/69
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5 May 1969	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial PK.	23d. LOCATION (City or Town) Glen Burnie	(County) (State) Md.
24 FUNERAL DIRECTOR Singleton Funeral Home		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE MAY 2 1969
		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04992

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04984

1. DECEASED-NAME (Type or print) Thaddeus W. Crapster			2a. DATE OF DEATH Month April Day 13 Year 1969			2b. HOUR 1:45 P.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Dec. 16, 1880		6. AGE (In years last birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission). STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Woodbine		13d. INS OR CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RFD #1/2		14. FATHER'S NAME First Mortimer D. Middle Crapster Last Crapster		15. MOTHER'S MAIDEN NAME First Georgetta Middle Warfield Last Warfield			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-01-6391		17. INFORMANT Address Mrs Robert R. Brannan, Towson, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the rectum DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Cardiovascular Disease							
19a. DATE OF OPERATION January 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1968 to April 13, 1969 , that (I) (we) last saw the deceased alive on April 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. Mynton Gaines Jr.		22c. DATE SIGNED April 14, 1969		22d. PHYSICIAN'S NAME (Type) L. Mynton Gaines Jr., M.D.		22e. ADDRESS 7800 York Rd. Baltimore, 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/16/69		23c. NAME OF CEMETERY OR CREMATORY Crapster Family Cemetery		23d. LOCATION (City or Town) (County) (State) Nr. Florence, Howard Co. Md.	
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04993

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04985

1 DECEASED NAME (Type or Print) PAUL LORN CRAWFORD			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month 4 Day 23 Year 1969			2b HOUR 3:30 M P		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 3/9/1910	6 AGE (in years last birthday) 59 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 4 Day 23 Year 1969		
7a BIRTHPLACE (State or foreign country) W. Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore		
10 CITY OR TOWN OF DEATH Monkton		11 NAME OF HOSP TAL. OR INSTITUTION (If not in hospital give street address) Monkton Road		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Tree Surgent		12b KIND OF BUSINESS OR INDUSTRY Tree		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Harford		13c CITY OR TOWN Street		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Jerry Road
14 FATHER'S NAME First Mack Middle Lorn Last Crawford				15 MOTHER'S MAIDEN NAME First Lora Middle Smallridge Last Smallridge				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO. (If yes give year or dates of service) WW 2 220-01-5448		17 INFORMANT ADDRESS RD #1 Velva M. Crawford Street, Md. 21154				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE A. M. France				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 4/23/69		
EXAMINER'S NAME (Type) A. M. FRANCE				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
				ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4/28/1969		23c NAME OF CEMETERY OR CREMATORY Rock Cave		23d LOCATION (City or Town) (County) (State) Rock Cave, Upshur, W. Va.		
24 FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.				25a REC'D BY REGISTRAR DATE APR 28 1969		25b REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> 04994 CERTIFICATE OF DEATH 04986 </div>										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
FRANK			WILLIAM			CRIST			Month Day Year April 18, 1969	3:45 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. COUNTY OF DEATH		
Male		White		9-21-11		57 YRS.		Baltimore		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland			USA				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital			Bethlehem Steel		Clerk		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland					Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		5219 Hazelwood Ave. 21206	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Martin J. Crist			Elizabeth Murphy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes			215-01-7113		Bertha M. Crist - 5219 Hazelwood Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 6</u> , 19 <u>69</u> , to <u>April 18</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>April 18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Artemio Villavania</u> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-18-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>DR. ARTEMIO VILLAVANIA, M.D.</u>						22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4-21-69		Holy Redeemer Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John C. Miller Inc-6415 Belair Road						APR 22 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR	
DORIS MAE CURRY						4 Month 24 Day 69 Year			6:35	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years lost birthday)		IF UNDER 1 YEAR		
FEMALE		CAUCASIAN		7-14-24		44 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Penna.		U.S.A.				BALTIMORE Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE			GREAT BALT. MED. CENTR							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Res. dence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM. IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		21234		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8604 Willow Oak Road	
14. FATHER'S NAME			15. MOTHER'S M.A.DEN NAME							
John Brady			Cleo M. Fillmore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
No			218 12 3974		Clyde E. Curry 8604 Willow Oak Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SECONDARY CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF BREAST/RIGHT</u> DUE TO, OR AS A CONSEQUENCE OF (c)									TWO DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 4-8, 19 69, to 4-24, 19 69, that (X) (we) lost saw the deceased alive on 4-24, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
WILLIAM YEH, M.D.									4-24-69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
WILLIAM YEH, M.D.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4-28-69		Parkwood Cemetery		Baltimore County Maryland				
24. FUNERAL DIRECTOR					25a. REC'D BY REG. STRAR		25b. REG. STRAR'S SIGNATURE			
William E. Johnson 8521 Loch Raven Blvd.					MAY 1 1969		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04996									
CERTIFICATE OF DEATH									
04988									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Domenica M. Dagostaro						April 19 69			6145
3 SEX		4. RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		6-19-98		70 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Italy			U.S.A.				Baltimore Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Towson			St. Joseph Hospital			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Baltimore		Parkville				8411 Harford Rd., 21234
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Philip Zanghi			Salvatora Miraglia						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT			Address	
No			216-05-9897		Mr Sam Dagostaro			Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>4107</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction Acute</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardio Vascular Disease</u> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/18/</u> , 19 <u>69</u> , to <u>4/19/</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/19/</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Lilia C. Baldonado</u> DEGREE						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-19-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Lilia C. Baldonado M.D.</u>						22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			4/23/69		Holy Redeemer		Baltimore, Maryland		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J Ruck Inc. Baltimore, Maryland						APR 21 1969		<u>Charles Judge</u>	

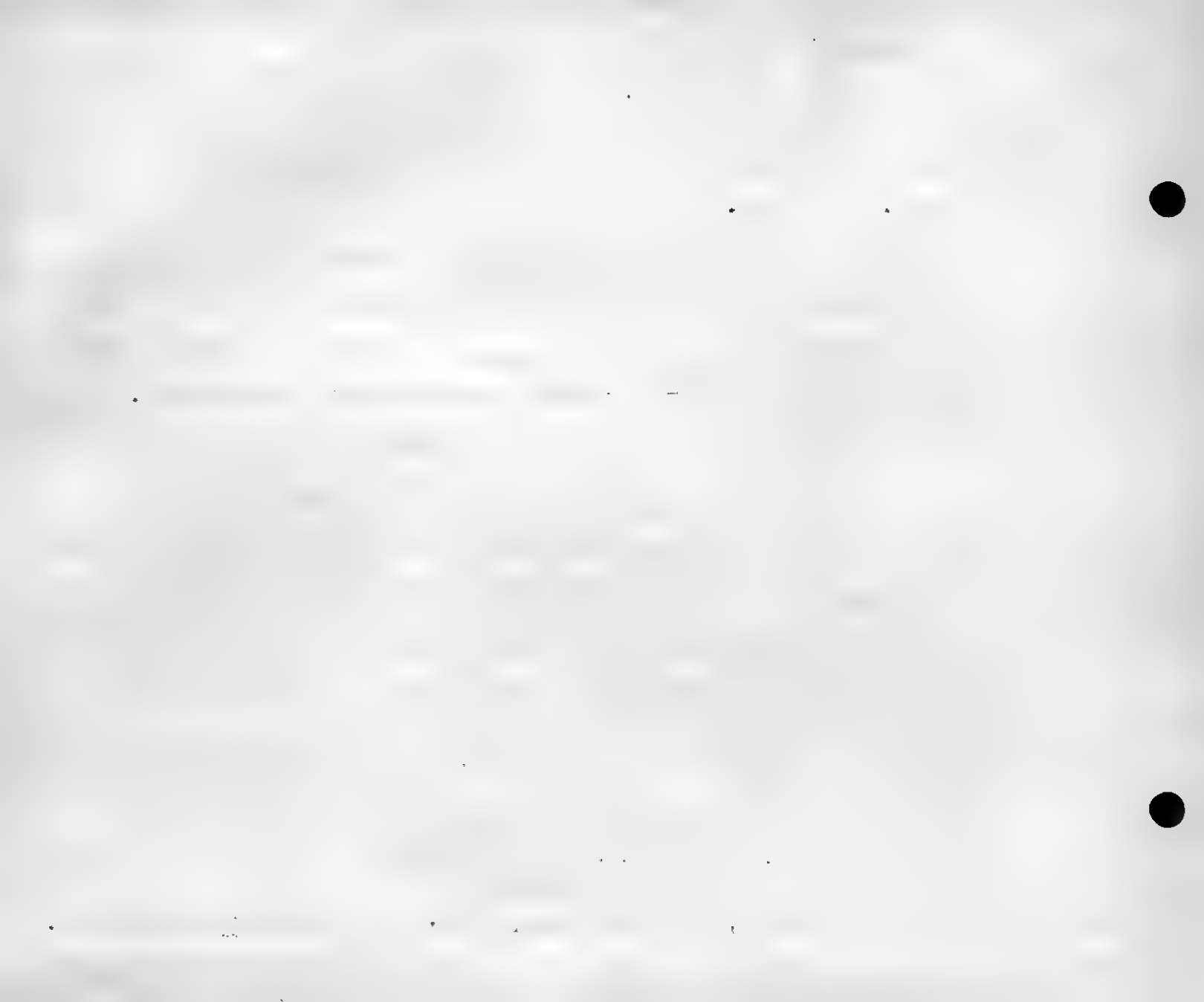
1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Film 411 4/11/69 kdk 04997													DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													04989												
1 DECEASED-NAME (Type or Print) First BARBARA Middle L. Last DAILEY													2a DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> April 3, 1969				2b HOUR 8:45 AM																					
3 SEX Female			4 RACE White			5 DATE OF BIRTH			6 AGE (in years last birthday) 39 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN			2c DATE PRONOUNCED DEAD Month April, 3, Year 1969				2d HOUR 8:45 AM																
7a BIRTHPLACE (State or foreign country) Penna.						7b CITIZEN OF WHAT COUNTRY? USA.						8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						9. COUNTY OF DEATH Baltimore Md																				
10. CITY OR TOWN OF DEATH Catonsville						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Forest Haven Nursing Home						12a US-JA-E OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse						12b KIND OF BUSINESS OR INDUSTRY Hospital																				
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland						13b COUNTY Baltimore						13c CITY OR TOWN Catonsville						13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						13e STREET AND NUMBER 117 Frederick Ave						13f Ingle Side Ave. Edmondson Ave								
14 FATHER'S NAME First Charles Louis Middle DeBouck Last													15 MOTHER'S MAIDEN NAME First Cecelia Theresa Middle Anderson Last																									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No													16b. SOCIAL SECURITY NO 212- 24 - 2482													17. INFORMANT Charles DeBouck ADDRESS Cumberland Md.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic cardiovascular disease																																						
19a. DATE OF OPERATION													19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State																										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																						
ACTUAL SIGNATURE Ronald N. Kornblum						EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)						22b. DATE SIGNED 4-4-69																
23a BURIAL, CREMATION, REMOVAL (Specify) Burial						23b DATE April 7, 1969						23c NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.						23d LOCATION (City or Town) (County) (State) Cumberland Allegany Md.																				
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.													ADDRESS													25a REC'D BY REG STRAR APR 8 1969				25b REGISTRAR'S SIGNATURE Charles Judge								

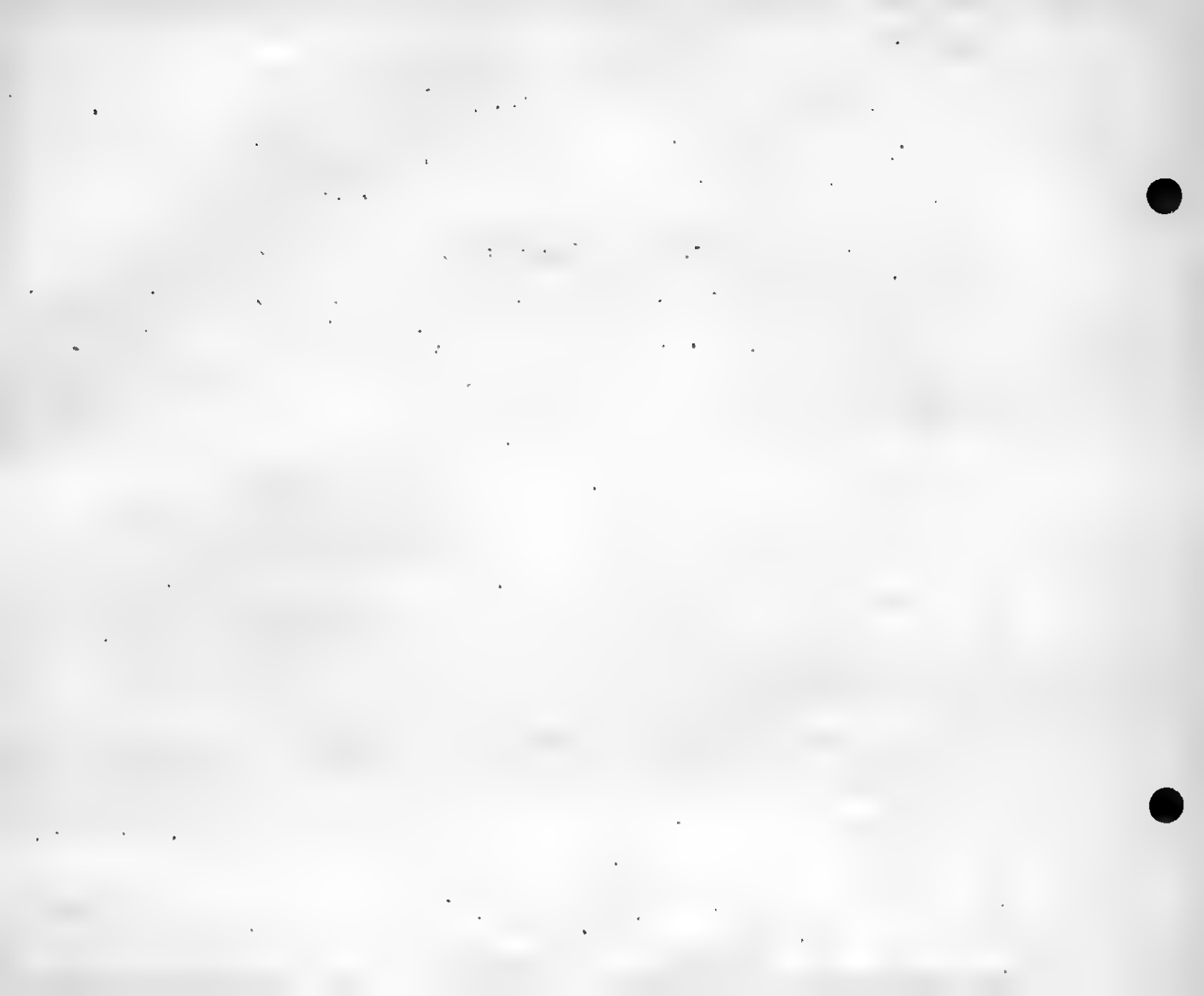


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
304 REV 1-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) LOHMAN			First Middle Last DAVIS			2a. DATE OF DEATH Month 4 Day 21 Year 69		2b. HOUR 5:05 A	
3 SEX Male		4 RACE W		5. DATE OF BIRTH 3.1.1900		6. AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore County Md.			
10 CITY OR TOWN OF DEATH Mount Wilson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Frederick Md. 20760	
14 FATHER'S NAME First Middle Last GEORGE DAVIS			15. MOTHER'S M maiden name First Middle Last EMMA HALL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterial hypertension DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 1/2 hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) For Advanced pulmonary Tuberculosis!									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11.26 , 19 68 , to 4.21 , 19 69 , that (I) (we) lost the deceased alive on 4.21 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W Newcomer		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4.21.1969			
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/24/69		23c. NAME OF CEMETERY OR CREMATORY Emory Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Emory Grove Montg. Md.			
24. FUNERAL DIRECTOR George R. Browder		ADDRESS Rockville		25a. REC'D BY REGISTRAR APR 24 1969		25b. REGISTRAR'S SIGNATURE Thomas Judge			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04999

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04991

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year		2b. HOUR	
ALBERT		E.				DEBAUGH		April 17, 1969		?	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month April Day 17, Year 19 69	
Male	White	9-16-1895		73 YRS						?	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				Md.	
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Medical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Electrician		12b. KIND OF BUSINESS OR INDUSTRY Railroad					
3a. USUAL RESIDENCE (Where deceased lived, if admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 110 Margate Rd.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Albert DeBaugh								Margaret Lewis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW I		16b. SOCIAL SECURITY NO 705-09-8084		17. INFORMANT Bessie M. DeBaugh		ADDRESS 110 Margate Rd. Lutherville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4-124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 4/18/69			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-21-1969		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204						25a. REC'D BY REGISTRAR DATE APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

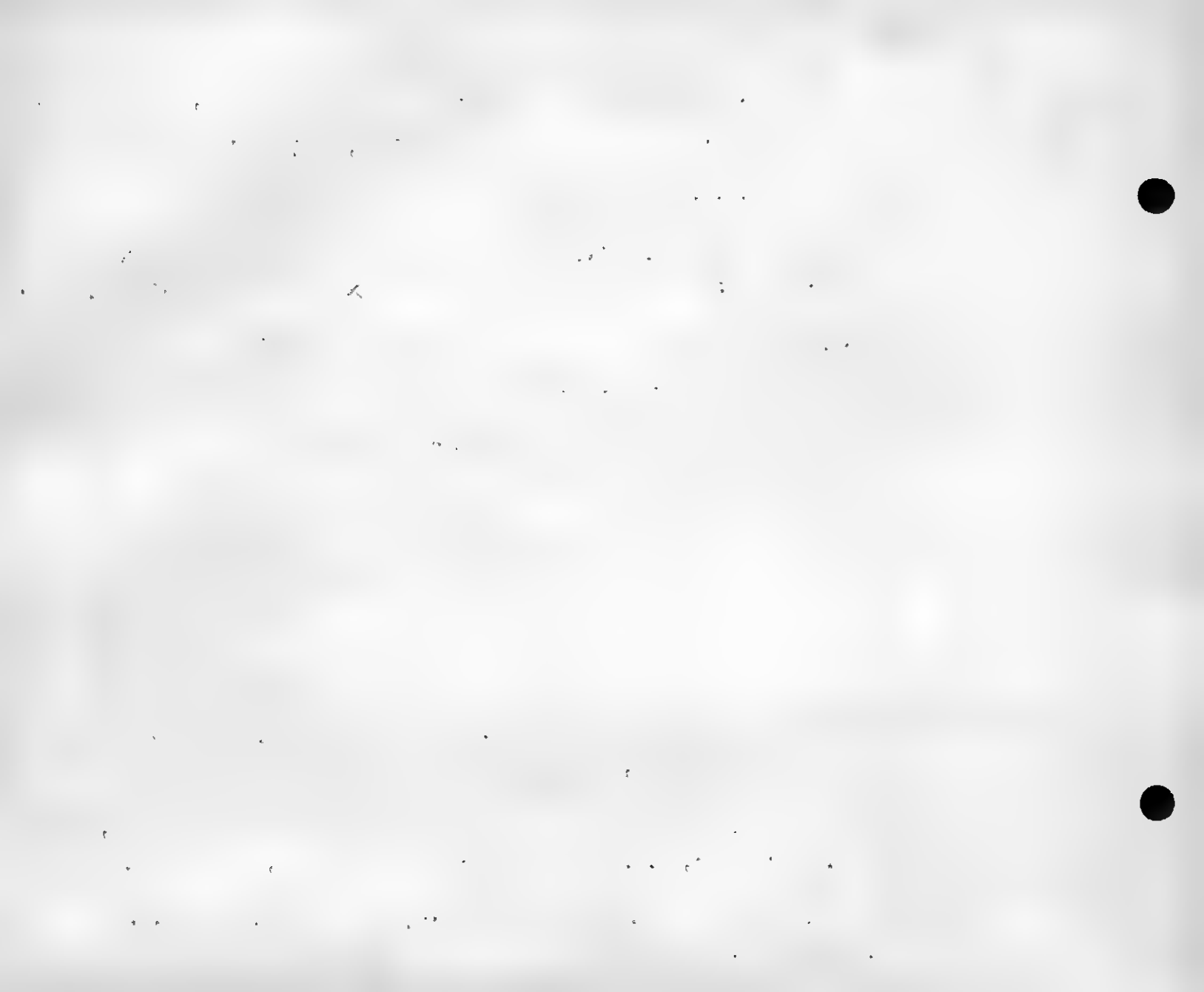
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) Katherine T. E. Deckret			2a. DATE OF DEATH Month 4 Day 22 Year 69			2b. HOUR 6:45 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH Dec. 3, 1885		6 AGE (In years last birthday) 83 YRS		7c. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore.			
10. CITY OR TOWN OF DEATH Catonsville.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife - Char woman		12b. KIND OF BUSINESS OR INDUSTRY Office Buildings			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE Md		13b. COUNTY 136. COUNTY		13c. CITY OR TOWN Balto.		13d. NSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1434 Towson St.	
14 FATHER'S NAME First Middle Last Charles Thomas			15 MOTHER'S MAIDEN NAME First Middle Last Mary Elizabeth Dingle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 218-18-324		17 INFORMANT Address Records: Spring Grove State Hosp.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema. DUE TO, OR AS A CONSEQUENCE OF Bilateral pneumonitis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs 4 weeks	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) A.S.C.V.D., Renal failure, Diverticulosis of the colon.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 4. 24. 19 67, to 4. 22. 19 69, that (I) (we) last saw the deceased alive on 4. 22. 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Diomidis L. Pirovolidis				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4. 22. 69.			
22d. PHYSICIAN'S NAME (Type) Diomidis L. Pirovolidis				22e. ADDRESS Spring Grove St. Hosp. Baltimore, Md. 21268					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-69		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) Baltimore		23e. (County) (State) Maryland	
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 24 1969		25b. REGISTRAR'S SIGNATURE John J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First ANTOINETTE		Middle (Tena)		Last DEMORESKE		2a. DATE OF DEATH APRIL Month 22, Day 1969		2b. HOUR 2:50AM
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH SEPTEMBER 23, 1907		6. AGE (In years last birthday) 61 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH BALTIMORE				Md.
10 CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY Aetna Shirt Co				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13b. RESIDENCE BEFORE BALTIMORE		13c. CITY OR TOWN		13d. INS-DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 3200 PUTTY HILL AVE.#21234		
14. FATHER'S NAME Wladyslaw Brzozowski		First Middle Last		15. MOTHER'S MAIDEN NAME Leokadya Popowski		First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 215-03-4476		17 INFORMANT Thomas Demoreski		Address 3200 Putty Hill Ave		34
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>April 4</u> , 19 <u>69</u> , to <u>April 22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>A. Villafania</i>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED April 22, 1969				
22d. PHYSICIAN'S NAME (Type) A. Villafania, M.D.				22e. ADDRESS 7620 York Road, Towson, Md. #21204						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/25/69		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore 21224, Md				
24. FUNERAL DIRECTOR George A. Weber		ADDRESS 705 South Ann Street		25a. REC'D BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05002		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04994	
Item 10 Film 411 4/14/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) Frances		First C. Middle Dettmer Last		2a. DATE OF DEATH 4 Month 3 Day 69 Year	
3. SEX Female		4 RACE Caucasian		5. DATE OF BIRTH April 26, 1896	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1904 Glen Keith Blvd.		9. COUNTY OF DEATH Baltimore	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Housewife	
14. FATHER'S NAME First John Middle H. Last Deinlein		15. MOTHER'S MAIDEN NAME First Jennie Middle Neuberger Last		12b. KIND OF BUSINESS OR INDUSTRY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-09-6220 D		17. INFORMANT Mrs. Lucille M. Holland Address 1904 Glen Keith Blvd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno-Carcinoma of Ascending Colon DUE TO, OR AS A CONSEQUENCE OF (c) 1/15/69		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION 1/15/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of Colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1/15/69 , 19 69 , to 4/3 , 19 69 , that (I) (we) last saw the deceased alive on 4/3 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James E. White		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 3, 1969	
22d. PHYSICIAN'S NAME (Type) James E. White M.D.		22e. ADDRESS 5214 Harford Road Baltimore Maryland			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 4/5/69		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS 5305 Harford Road 21214		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
VR A15 (4) 30M REV 1-68		25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE John Charles Judge	



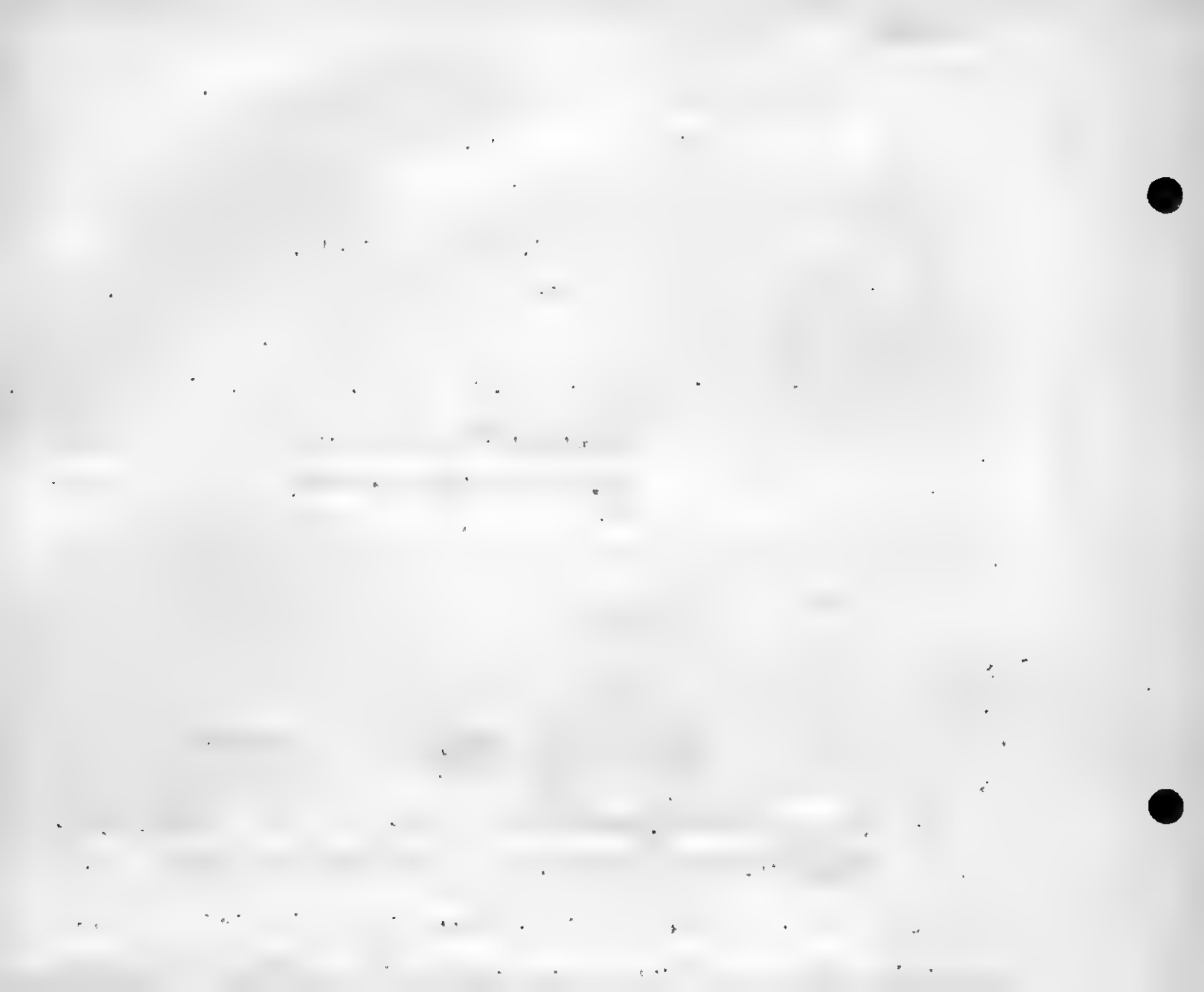
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

10E-MW-ami-ms-
ms-4 - 4 CEMENT CERTIFICATION CARDS

514

04995

1. DECEASED NAME (Type or print) MARTHA LUCY DEVEREAUX		Middle Last April 23, 1969		2a. DATE OF DEATH April 23, 1969		2b. HOUR 10:00	
3 SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 29, 1915		6. AGE (In years last birthday) 53 YRS	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore County,	
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 217 Langley Rd. 21221		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Secret.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Gustave Van Cutsen		15. MOTHER'S MAIDEN NAME First Middle Last Mary p. Van Acker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 061-03-2280	
17. INFORMANT Mr. Bernard A. Devereaux-217 Langley Rd.		18. ADDRESS 217 Langley Rd. 21221		19. PHONE NO. 217-1221		20. SIGNATURE Raymond D. Bahr	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the breast DUE TO, OR AS A CONSEQUENCE OF (c) last		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Mo.		23. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		24. SIGNATURE Raymond D. Bahr	
25a. DATE OF OPERATION 4/10/69		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic Carcinoma		25c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		25d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		26b. TIME OF INJURY HOUR A.M. Month Day Year 19		26c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		26d. SIGNATURE Raymond D. Bahr	
27a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		27b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		27c. LOCATION Street or R.F.D. No. City or Town County State		27d. SIGNATURE Raymond D. Bahr	
28a. I certify that (I) (this hospital) attended the deceased from 4/10/69 , 19 69 , to 4/24/69 , 19 69 , that (I) (we) last saw the deceased alive on 4/10/69 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		28b. SIGNATURE Raymond D. Bahr		28c. DATE SIGNED 4/24/69		28d. SIGNATURE Raymond D. Bahr	
29a. PHYSICIAN'S NAME (Type) RAYMOND D. BAHR		29b. ADDRESS ST. AGNES HOSPITAL		29c. DATE APR 28 1969		29d. SIGNATURE Charles Judge	
30a. BURIAL, CREMATION, REMOVAL (Specify) Burial		30b. DATE Apr. 25, '69		30c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		30d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
31. FUNERAL DIRECTOR H. Sander & Sons, Inc., Balto., Md.		32. ADDRESS H. Sander & Sons, Inc., Balto., Md.		33. REC'D BY REGISTRAR APR 28 1969		34. REGISTRAR'S SIGNATURE Charles Judge	



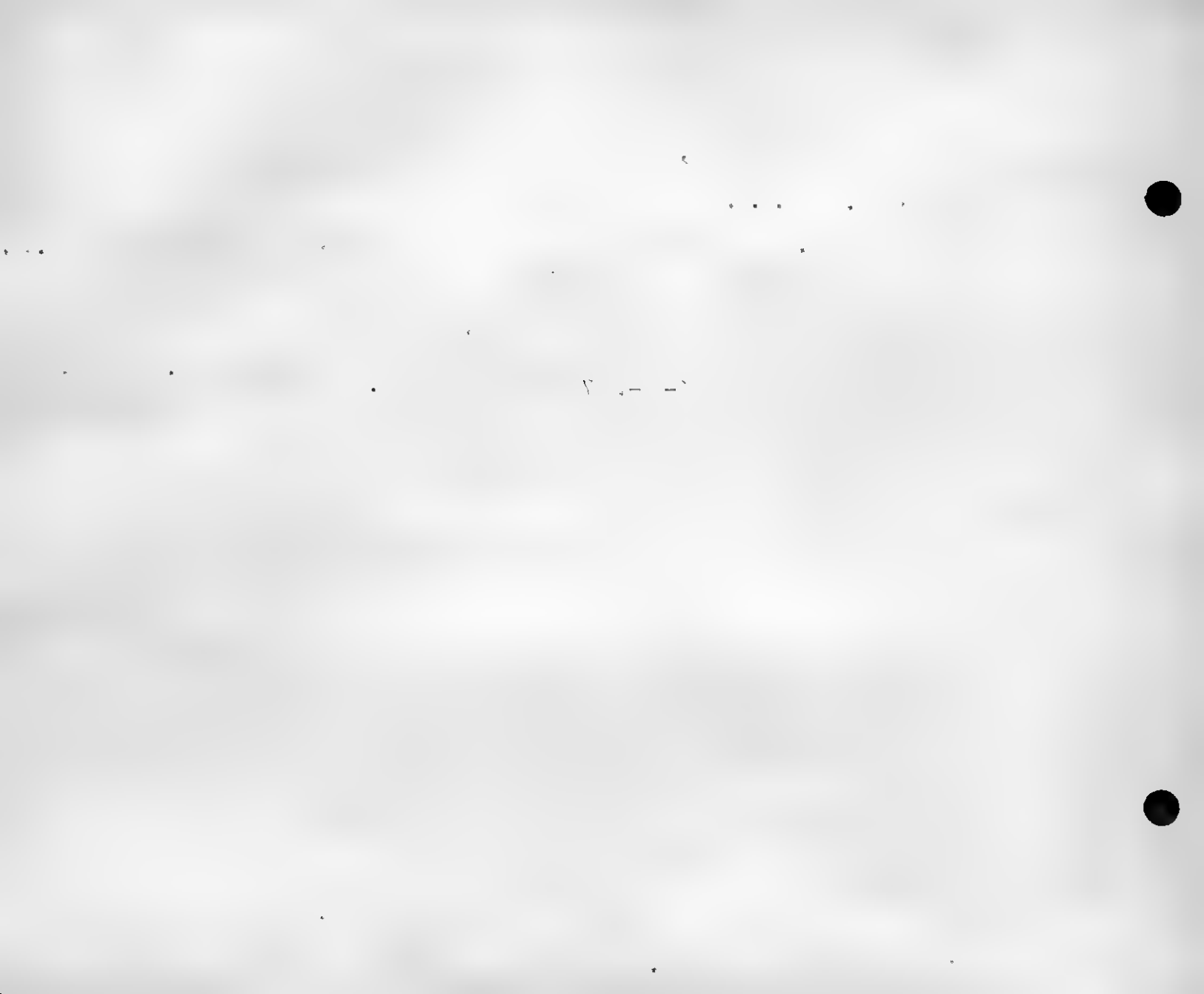
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
10M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04996		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF EST DEATH		2b HOUR			
RALPH			EDGAR		DIEHL		DIEHL		Month Day Year		19			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		
male		white		June 20, 43		25 YRS						10:15 A. M.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
Hampstead Md.			U.S.A.						Baltimore			Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Owings Mills Md.			103 Enchanted Hills			Plumber			Granston Pl.Co.					
13a USUAL RESIDENCE (Where deceased lived, if not institution - Residence before admission to hospital)			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Baltimore			Owings Mills						103 Enchanted Hills		
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME									
First Middle Last					First Middle Last									
Harry Diehl					Beulah Shaffer									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b SOCIAL SECURITY NO					17 INFORMANT				
NO					213-42-4257					Box 242 A. Windy Hill Rd Owings Mills Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot Wound of Chest														
955X DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? (Part) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					21b TIME OF INJURY Month, Day, Year HOURS MIN 4/28/19 69					21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Subj. shot self in chest				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home					21f LOCATION Street or R.F.D. No. City or Town County State 103 Enchanted Hills, Apt T1, Baltimore, Md.				
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Werner U. Spitz, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)					22b DATE SIGNED 4/29/69				
23a BURIAL, CREMATION, REMOVAL (Specify)					23b DATE					23c NAME OF CEMETERY OR CREMATORY				
Burial					5/2/69					Lake View Memorial Park				
23d LOCATION (City or Town) (County) (State)					23e LOCATION (City or Town) (County) (State)									
Baltimore					Carroll County Maryland									
24 FUNERAL DIRECTOR					25a REC'D BY REG STRAR					25b REGISTRAR'S SIGNATURE				
Loring Byers 8728 Liberty Rd. Randallstown					MAY 5 1969					[Signature]				

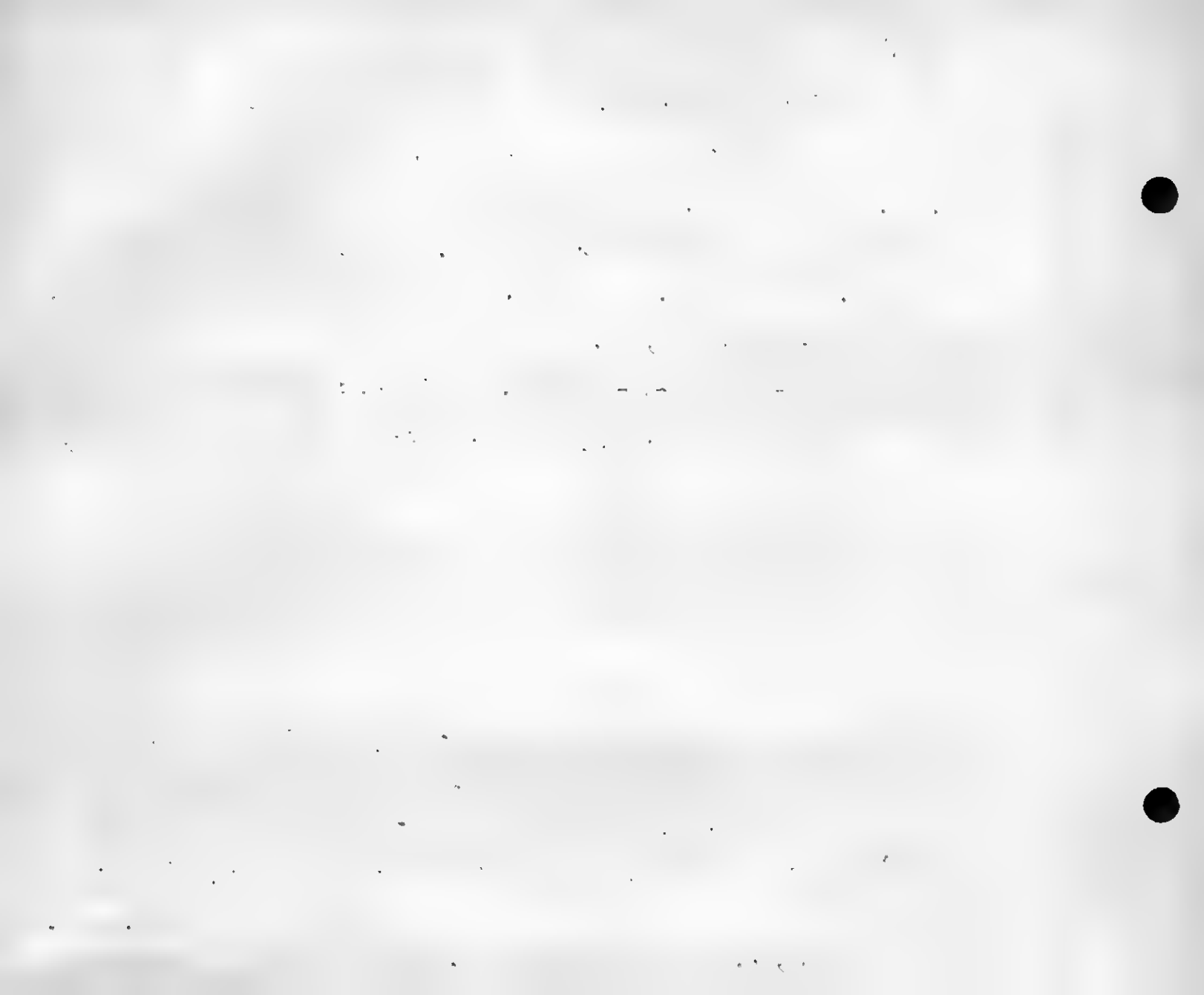


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VR 4-15-68
30M REV 11-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05005					CERTIFICATE OF DEATH			04997			
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR Min.		
Emily Crowley Ditman						April 30 1969			4:25 PM		
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
Female		White		Aug. 21, 1915			53 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Balto. Md.		U.S.A.					Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Woodlawn			6605 Windsor Mill Rd.			Housewife			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Balto.		Woodlawn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6605 Windsor Mill Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Arthur Crowley, Sr.			Zeta Biles								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT					
No			220-38-5428			Mr. William F. Ditman 6605 Windsor Mill Rd. Sr. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral artery aneurysm</u>										1 Hour	
174X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 8, 1952</u> to <u>April 30, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 29, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Edwin L. Pierpont, M.D.</u>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>4/30/69</u>		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
EDWIN L. PIERPONT, MD			8224 SHERIDAN PL. BALTO, 21217 MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			May 3, 1969		Lorraine			Woodlawn Balto. Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John T. Stansbury, Sr.			-6411 Windsor Mill Rd.			DATE MAY 2 1969			Charles Judge		



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05006

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

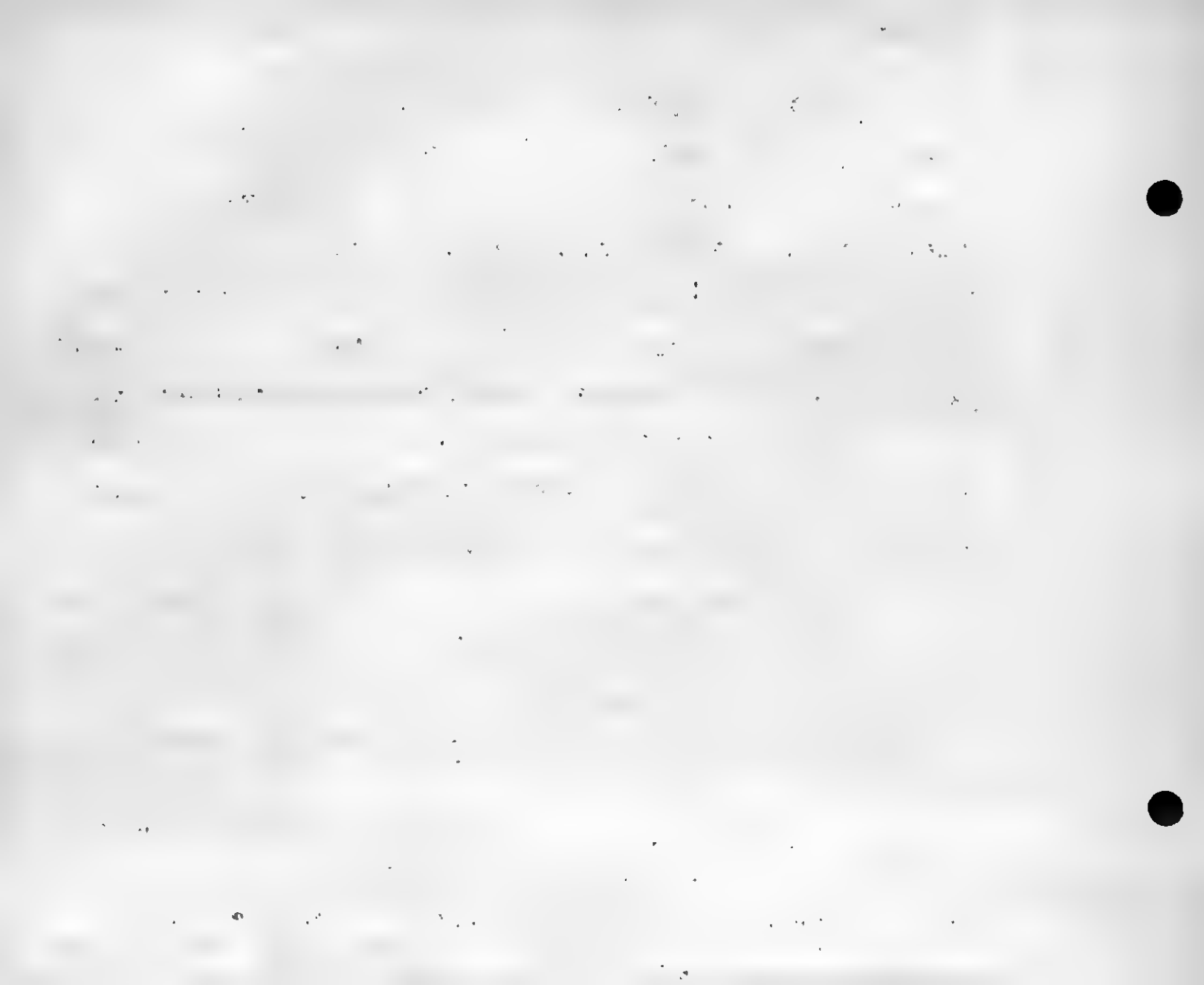
04990

1 DECEASED-NAME (Type or print) ISRAEL		First Middle Last		2a DATE OF DEATH Month Day Year April 24 1969		2b. HOUR 930 A	
3 SEX MALE		4. RACE WHITE		5 DATE OF BIRTH NOVEMBER 1877		6. AGE (In years lost birthday) 91 YRS.	
7a BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6821 WESTRIDGE RD.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CARPENTER		12b KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last UNKNOWN		15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO			
16b. SOCIAL SECURITY NO 220-09-0535		17 INFORMANT Address MRS. MINNIE SCHWARTZ, 6821 WESTRIDGE ROAD					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE							
19a DATE OF OPERATION		19b CONDIT.ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from November 67, 1967 to April 24, 1969 , that (I) (we) lost saw the deceased alive on April 23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Howard H. Gendason MD.				DEGREE MD.		22c DATE SIGNED April 24, 1969	
22d. PHYSICIAN'S NAME (Type) HOWARD H. GENDASON MD.				22e ADDRESS REISTERSTOWN, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 4-25-69		23c NAME OF CEMETERY OR CREMATORY BOBROIKER BENEFICIAL CIRCLE,		23d LOCATION (City or Town) (County) (State) ROSEDALE, MARYLAND	
24 FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD				25a REC'D BY REGISTRAR DATE APR 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

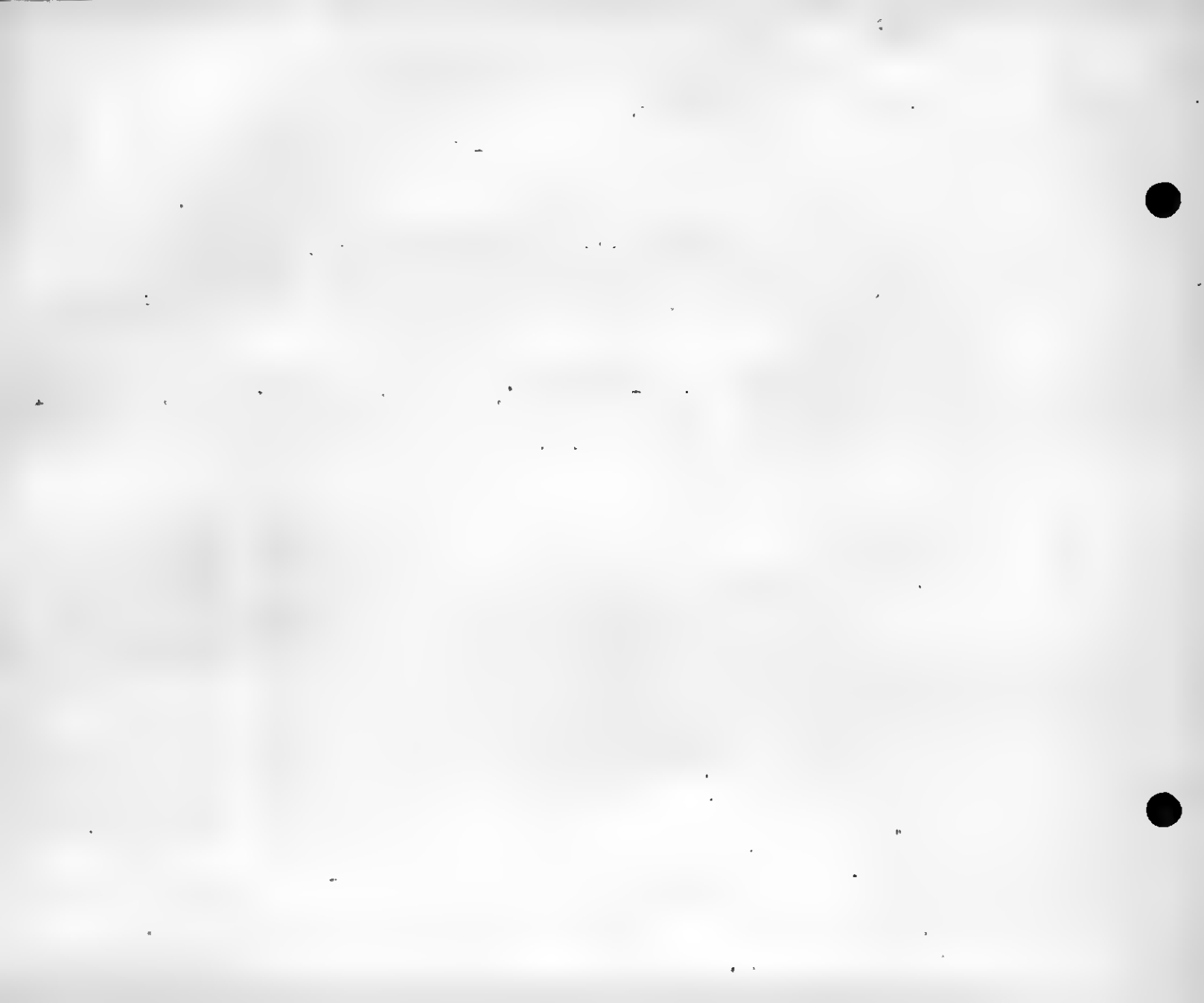
MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
04993																	
1. DECEASED-NAME (Type or print)			First JOSEPH			Middle FRANCIS			Last DOEMLING SR			2a. DATE OF DEATH APRIL Month, 19 , Day 1969 Year			2b. HOUR 6:30 AM		
3 SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 2/1/92			6 AGE (In years last birthday) 77 YRS			F UNDER 1 YEAR MONTHS			F UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.								
10. CITY OR TOWN OF DEATH FORT HOWARD, MD.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MOULDER			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTO			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 6902 HIGHVIEW AVENUE					
14. FATHER'S NAME First GEORGE			Middle DOEMLING			Last DOEMLING			15. MOTHER'S MAIDEN NAME First MARGARET			Middle - -			Last MICHAEL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) YES			(If yes give war or dates of service) WWI			16b. SOCIAL SECURITY NO 216 07 2181			17 INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY.																	
IMMEDIATE CAUSE (a) CHRONIC RESPIRATORY FAILURE												MONTHS					
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC GRANULOMATOUS DISEASE OF LUNGS												YEARS					
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APR 17 , 19 69 , to APR 19 , 19 69 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on APR 19 , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.																	
22b. SIGNATURE Alfonso A. Lopez			DEGREE APFONSO A. LOPEZ, MD.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 4 19 69								
22d. PHYSICIAN'S NAME (Type) APFONSO A. LOPEZ, MD.			22e. ADDRESS VAH, FT. HOWARD, MD.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE APRIL 22 1969			23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.								
24. FUNERAL DIRECTOR DIPPEL FUNERAL HOME			ADDRESS 7110 BELAIR RD BALTO., MD.			25a. RECEIVED BY REGISTRAR APR 22 1969			25b. REGISTRAR'S SIGNATURE [Signature]								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05008		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05000	
Item 13 Film 412 5/8/69 kk					
1. DECEASED-NAME (Type or print)			2a. DATE OF DEATH		2b. HOUR
DeLahue, Mary G. Miss.			Month April Day 28 Year 1969		6:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS
Female	White	10-21-1873		95 YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH	
Baltimore Md				Baltimore, Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Towson		Stella Maris Hospital			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
MD.		BALTIMORE/TOWSON	Baltimore		2832 St. Paul Street
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last			
Thomas Donahue		Frances Hines			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address	
		#215-32-0809		A.A. MADORAH DONAHUE 101 W. MONUMENT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic heart syndrome</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> , 19 <u>69</u> , to <u>4/28</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>David M. Engel</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-28-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Dr. David M. Engel M.D.</u>		22e. ADDRESS <u>312 Mockingbird Lane 21004</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)
BURIAL		5/1/69	CATHEDRAL		BALTIMORE, MD.
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
<u>H. W. Mears</u>		805 N. Calvert St. MAY 5 1969		<u>Charles J. ...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First JAMES		Middle G.		Last DONEY		2a DATE OF DEATH April Month 9 Day 1969 Year		2b HOUR 4:40 A
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3-10-1896		6. AGE (In years last birthday) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Martin Co.		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d INSIDE CITY (IM IS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5702 Beechdale Road		
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 219-16-8010		17 INFORMANT Mrs Esther B Doney		Address Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>General arteriosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from <u>March 31</u> , 19 <u>69</u> , to <u>April 9</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>April 9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Gualberto Gokim, Jr.</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-9-69				
22d. PHYSICIAN'S NAME (Type) Gualberto Gokim, Jr., M.D.		22e ADDRESS 7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/11/69		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland				25a. REC'D BY REGISTRAR APR 9 1969		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

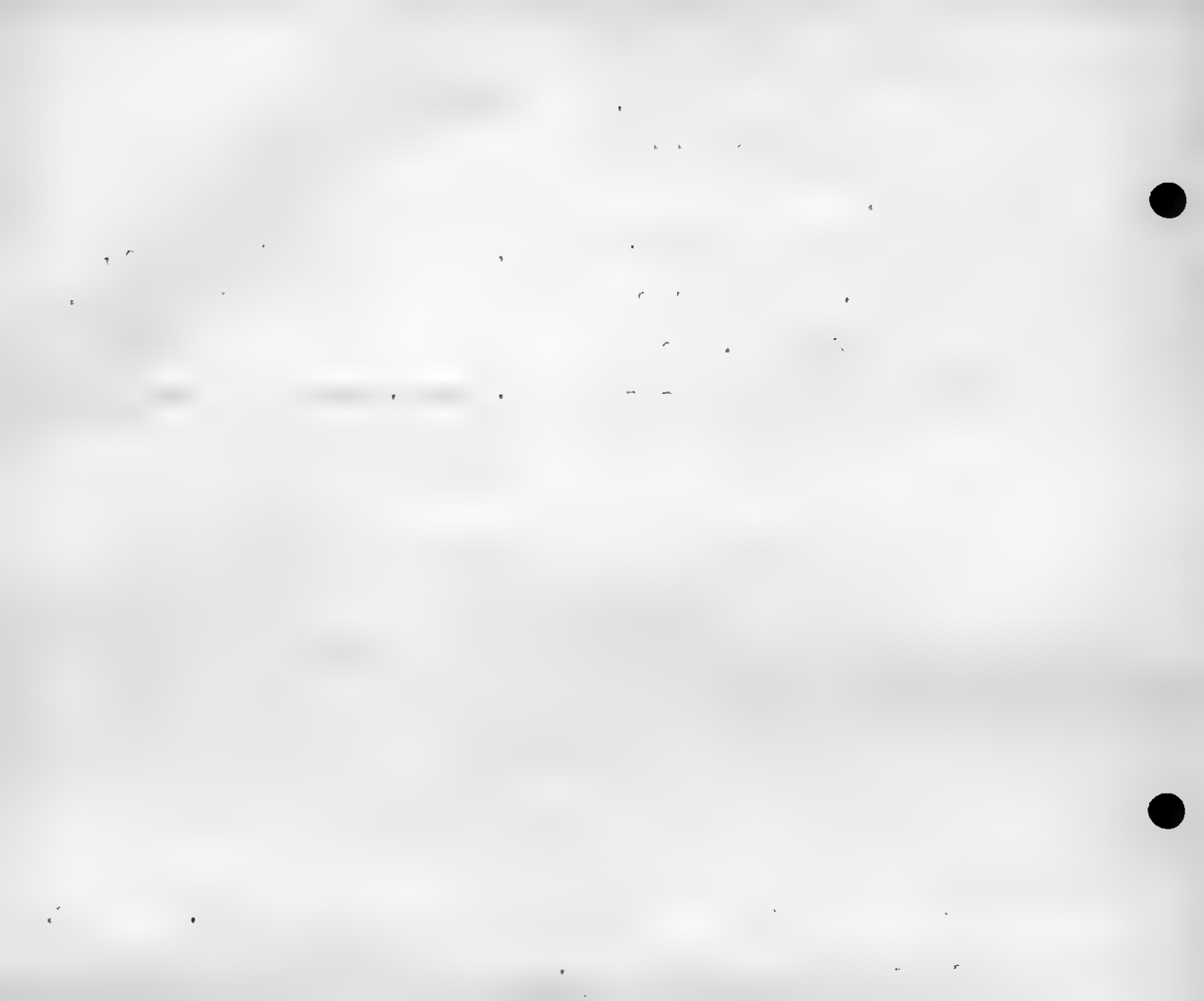
05010

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05002

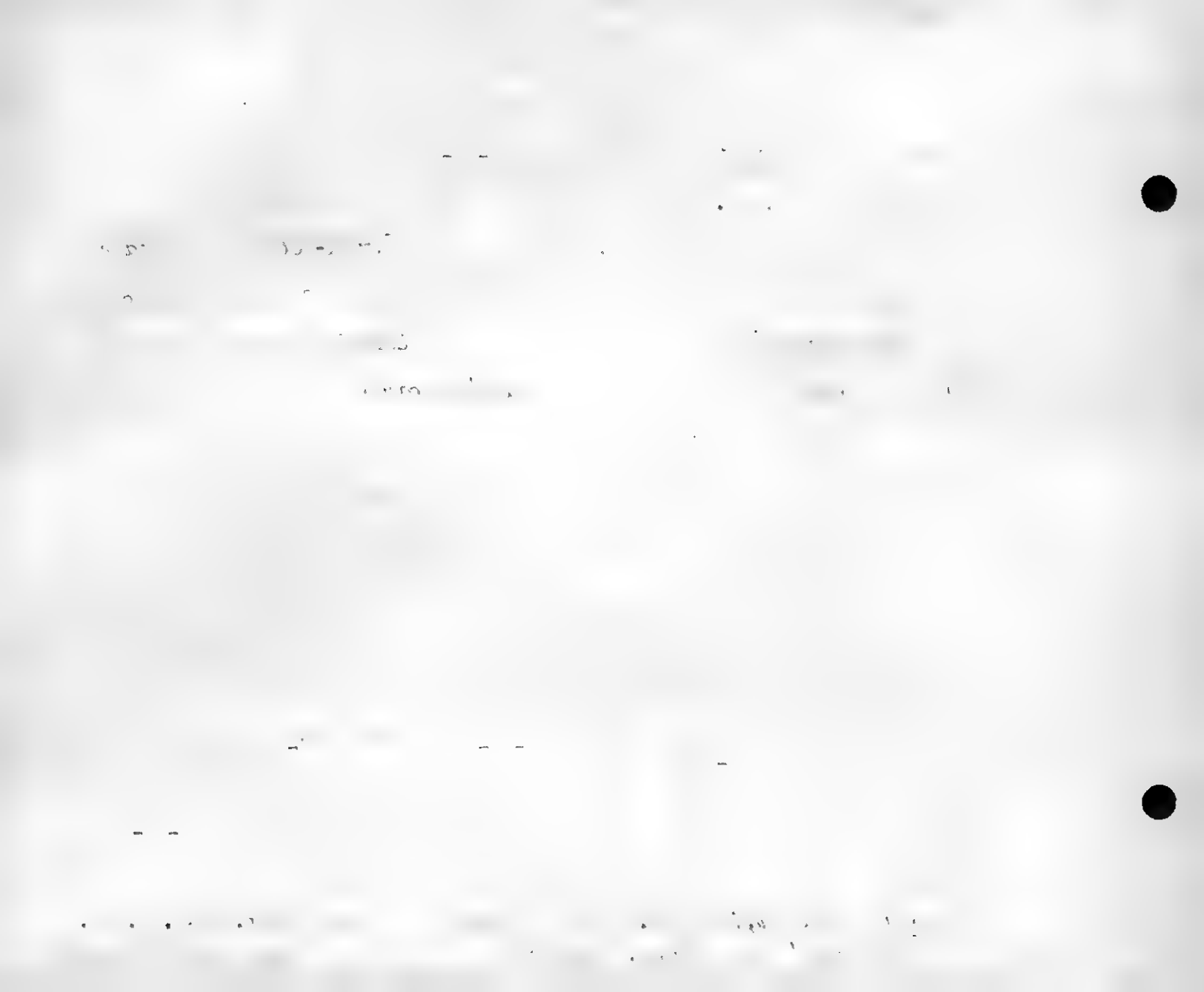
1. DECEASED-NAME (Type or Print) Carroll			First M.			Middle Donnelly			Last			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> April 4 1969			2b. HOUR 5 PM														
3. SEX male			4. RACE white			5. DATE OF BIRTH April 8, 1910			6. AGE (In years last birthday) 58 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0			IF UNDER 24 HRS. HOURS 0 MIN. 0														
7a. BIRTHPLACE (State or foreign country) Balto. Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore			2c. DATE PRONOUNCED DEAD Month April Day 4 Year 1969			2d. HOUR 5 PM														
10. CITY OR TOWN OF DEATH Towson						11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 963 Fairmount Ave.						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Fireman Balto. City						12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Md.						13b. COUNTY Balto.						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET AND NUMBER 963 Fairmount Ave.					
14. FATHER'S NAME Martin						First J. Middle Donnelly						15. MOTHER'S MAIDEN NAME Ella						First McNally											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						(If yes give war or dates of service)						16b. SOCIAL SECURITY NO 216-05-2254						17. INFORMANT Mrs. Helen C. Donnelly						ADDRESS Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY- 753X IMMEDIATE CAUSE (a) Strangulation from Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
MEDICAL CERTIFICATION																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE Charles F. Donnelly						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 4/4/69																	
EXAMINER'S NAME (Type) Charles F. Donnelly						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																	
ADDRESS (Street, city, town, or county)																													
23a. BURIAL, CREMATION, REMOVAL (Specify) burial						23b. DATE 4/8/69						23c. NAME OF CEMETERY OR CREMATORY New Cathedral						23d. LOCATION (City or Town) (County) (State) Balto. Md.											
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home						ADDRESS 6500 York Rd. Balto. Md. 21212						25a. REC'D BY REGISTRAR APR 9 1969						25b. REGISTRAR'S SIGNATURE Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (Pages 1 and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05011										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05003									
Item 6 Film 411 4/22/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED NAME (Type or print)					First Middle Last					2a. DATE OF DEATH Month Day Year					2b. HOUR														
James O'Brien Donnelly										April 13 1969					12:47														
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (n years last birthday)			7a. IF UNDER 1 YEAR			7b. IF UNDER 24 HRS														
male			white			5-16-1897			71 72 YRS.			MONTHS DAYS HOURS MIN																	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH																				
Ireland			U.S.A.						Baltimore Md.																				
10 CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
Towson					St. Joseph					Farmer-retired					Farm														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
Maryland					Baltimore					Baltimore					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					17 Linden Terrace									
14. FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last																								
James Donnelly					Elizabeth Donnelly																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)					16b. SOCIAL SECURITY NO.					17 INFORMANT Address																			
No					None					Family records																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diffuse Gastrointestinal bleeding																													
DUE TO, OR AS A CONSEQUENCE OF (b) hypoprothrombinemia																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (X) (this hospital) attended the deceased from 4-13-1969, to 4-13-1969, that (X) (we) last saw the deceased alive on 4-13-1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.																													
22b. SIGNATURE Scillini M.D. DEGREE										ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED 4-13-69														
22d. PHYSICIAN'S NAME (Type) INES CILLINI M.D.										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					April 16, 1969					St. John's Cemetery					Long Green, Balto. Co., Md.														
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland										25a. REC'D BY REGISTRAR DATE APR 18 1969					25b. REGISTRAR'S SIGNATURE J. Charles Judge														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

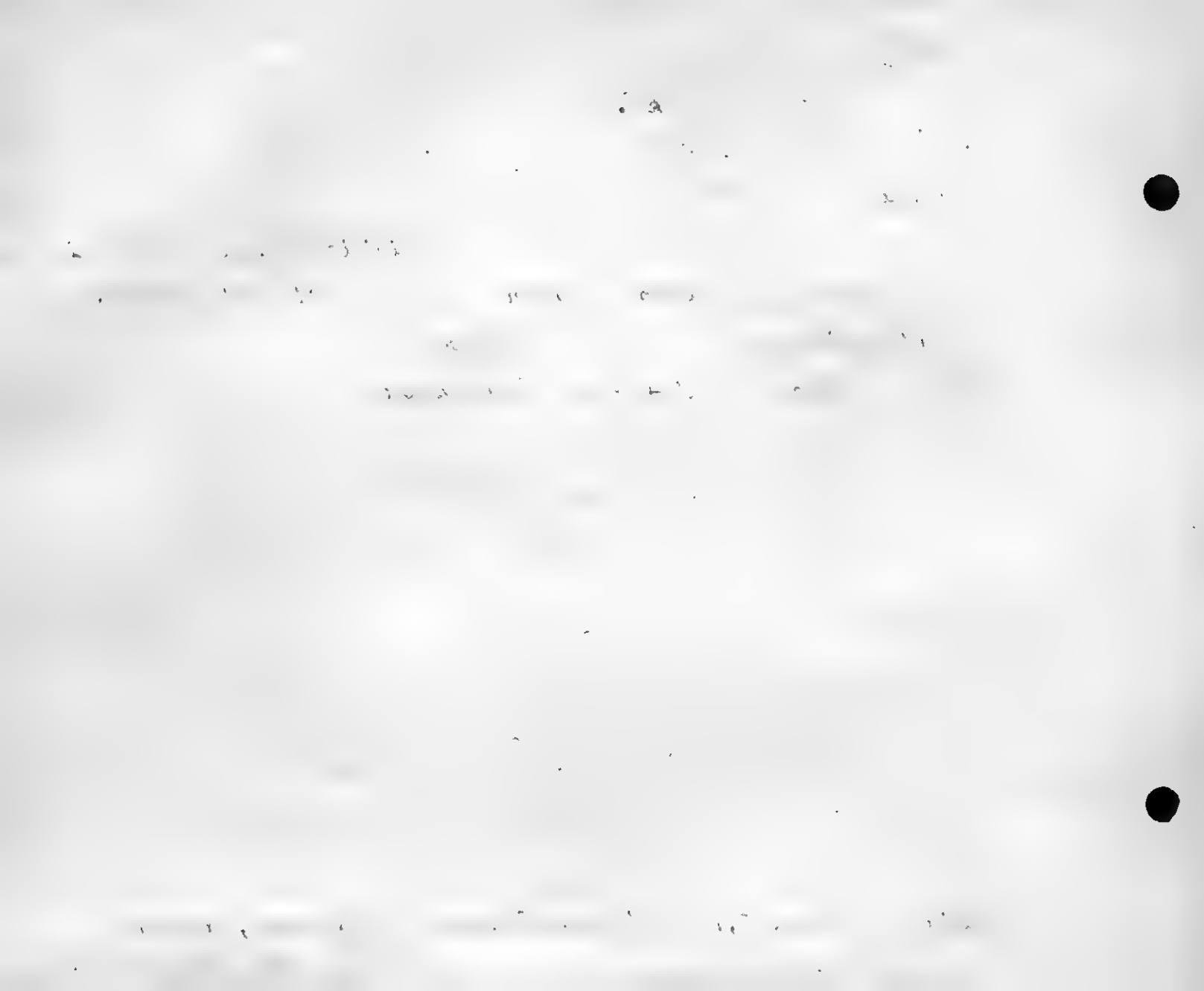
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05012					05004				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last William Earl Dorfman					4 Month 8 Day 69 year				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7b. UNDER 1 YEAR	
male		white		11/5/86		82 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Russia		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR IND. STRY			
Baltimore		Baltimore County Gen.		MUSIC		INSTRUCTOR			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Balto.		Balto.				6741-C Townbrook Drive	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MA DEN NAME First Middle Last				
UNKNOWN					UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
NO		126-14-4184		MRS. JENNIE DORFMAN, 6741 C TOWNBROOK DR.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PRIMARY CARCINOMA OF Rt LUNGS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>MO-YRS</u> <u>YRS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PULMONARY EDEMA + CONGESTION</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
<u>Aurora T. Hipolito M.D.</u>		4/8/69		BALTO. COUNTY GEN. HOSP.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
CREMATION		4-11-69		LOUDON PARK		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				APR 14 1969		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05013		MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05005	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P M
LEON			D.C.	DOROSZ	4 14 69		9:20
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE	CAUCASIAN		12-11-09		59 YRS.		
7a. BIRTH-PLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland	USA				BALTIMORE		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work-norm life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		GREAT BALT MED CENTER		District Manager		Food Fair Corp	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
Maryland		Baltimore		Towson		8113 Bellona Avenue	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last		
Anthony Dorosz					Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address			
No		None		217-03-0599 Family records			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u>							24 hrs
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) <u>CARCINOMA OF AMPULLA OF VATER WITH</u>							
stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF <u>METASTASES</u>							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4-12&13-69		CA OF AMULLA OF VATER AND POST-OP BLEEDING		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (1) (the doctor) attended the deceased from <u>4-25</u> , 19 <u>69</u> , to <u>4-14</u> , 19 <u>69</u> , that (2) (we) lost saw the deceased alive on <u>4-14</u> , 19 <u>69</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (3) (we) (did) (dissect) view the body after death.		22b. SIGNATURE <u>Richard C. Smith M.D.</u>		22c. DATE SIGNED 4-15-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
RICHARD SMITH, M.D.		6701 N CHARLES ST BALT, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		April 17, 1969		Holy Cross Cemetery		Baltimore, Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John Burns Sons		Towson		DATE APR 18 1969		Charles J. Judd	



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR
WILLIAM		T.		DORSEY		April		Month 30 Day 1969 Year		6A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS
Male		White		Dec. 21, 1883.		85 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		USA				Baltimore, Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Towson		Towson Convalescent Home		Retired Salesman		Millinery				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY, AM TS?		13e. STREET AND NUMBER		
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2958 Harford Rd.		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		
				Dorsey				Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No						Mr. Fred W. Dorsey, 9121 Covered Bridge Rd.				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Arteriosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b.)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or RFD No City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work										
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 10, 1968</u> to <u>April 30, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)						
<u>Laurence C. Post M.D.</u>		<u>4/30/69</u>		<u>LAURENCE C. Post</u>						
				22e. ADDRESS						
				<u>6805 York Rd Baltimore Md</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		<u>5/2/69.</u>		Parkwood Cemetery		Baltimore, Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				DATE <u>MAY 1 1969</u>		<u>Charles J. J...</u>				

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VR A19 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

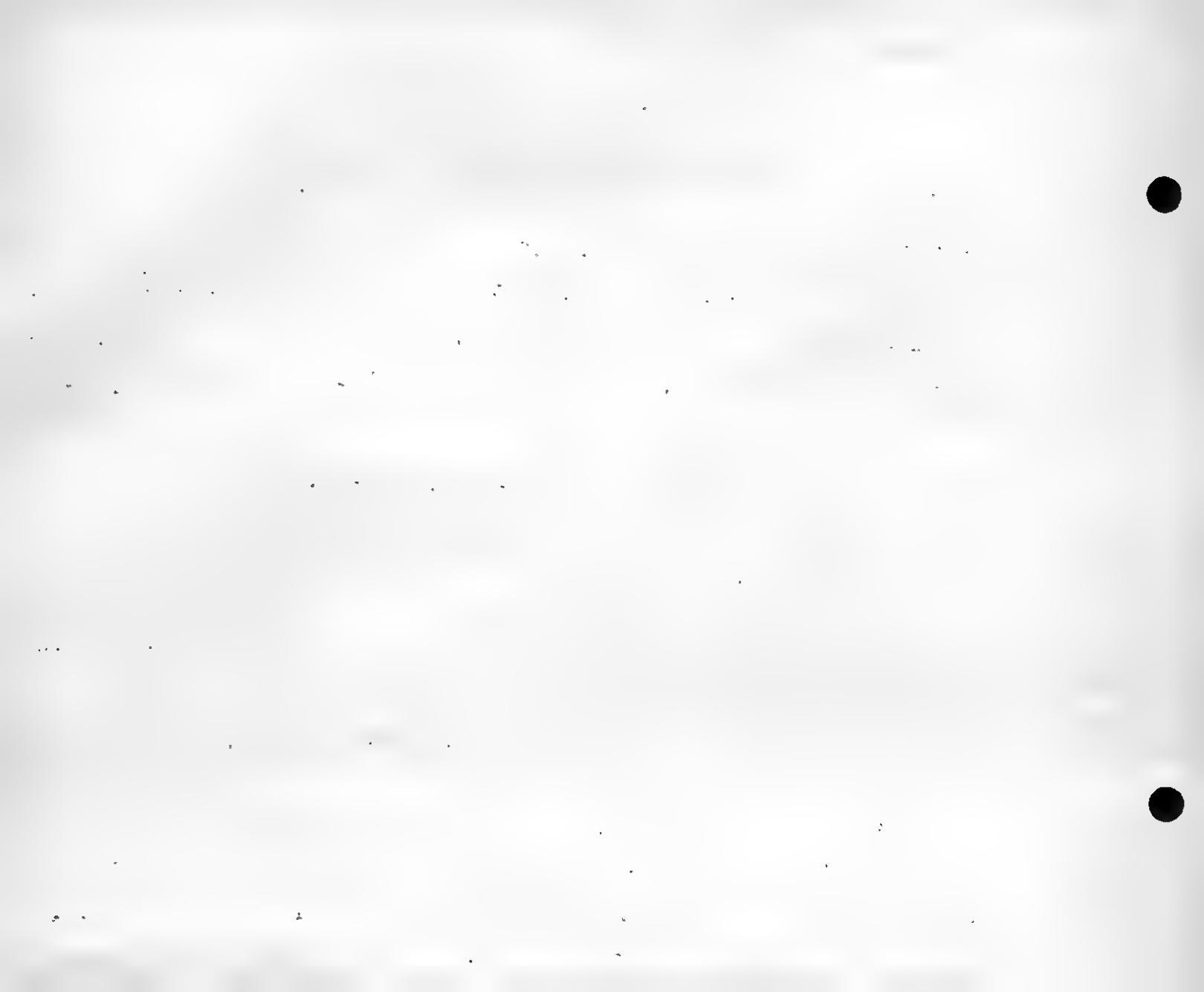
05015

CERTIFICATE OF DEATH

05007

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
CARROLL		L.		DRURY	Month 4 Day 16 Year 1969			11:10 AM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	Caucasian		5-16-1891		77 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MD		U.S.A.				Baltimore Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		Greater Balto. Med. Center						C & P Telephone		
13a. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
md		Balto.		Balto				1613 Four Georges Ct.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Charles				Drury	Anna				Dunnigan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO				212-05-4000		Mrs Bessie Drury		apt. B-1 1613 Four Georges Ct		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis										
4124 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Arteriosclerotic cardiovascular disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Carcinoma of lung and diverticulitis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County	State
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 4/3, 1969, to 4/16, 1969, that (I) (we) last saw the deceased alive on 4/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
John E. Adams										4/16/69
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
John E. Adams, M. D.						Greater Baltimore Medical Center				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
Burial		Apr. 19, 1969		Oak Lawn Cemetery		Balto.			md.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Shelma R. Hoffmann				3218 Hudson St		DATE APR 18 1969		Charles Judge		

MEDICAL CERTIFICATION



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05016

CERTIFICATE OF DEATH

05008

1. DECEASED NAME (Type or print) <i>Alva Gertrude Duckworth</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>6</i> Year <i>69</i>			2b. HOUR <i>8:30 PM</i>					
3. SEX <i>F</i>		4 RACE <i>W.</i>		5 DATE OF BIRTH <i>9-29-87</i>		6 AGE (In years last birthday) <i>81</i> YRS		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore County</i>					
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Balto Co Gen Hosp.</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Nurse</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>		13b COUNTY <i>Balto.</i>		13c CITY OR TOWN <i>Balto.</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>3628 Eitemiller Rd.</i>			
14 FATHER'S NAME First <i>Charles</i> Middle <i>Coleman</i> Last <i>May</i>			15 MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i>May</i> Last <i>May</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO <i>4109</i>			17 INFORMANT <i>ANNA Smith-2117 Northland Rd B. Seibert, Balto. Co. Gen. Hosp.</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>ASAB</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASAB</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>GI bleeding etiology unknown.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>April 3, 1969</i> to <i>April 6, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 3, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Boon Umanin</i>		DEGREE <i>BOON UMANIN</i>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>April 6, 69</i>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>ARMACOST FUNERAL CHAPEL</i>		22f. ADDRESS							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <i>4-9-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>LORRAINE Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>BALTO, Md</i>					
24. FUNERAL DIRECTOR <i>ARMACOST FUNERAL CHAPEL</i>		25a. REC'D BY REGISTRAR <i>APR 8 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 10, 11, 13, 14 & 15
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05003
05017
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last BRIAN TIMOTHY DUKE			2a. DATE OF DEATH Month Day Year APRIL 8 69		2b. HOUR 1:30
3 SEX MALE	4 RACE CAU.	5 DATE OF BIRTH 6-20-68	6. AGE (In years lost birthday) 9 mos. YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS M.M. 7	IF UNDER 24 HRS. HOURS M.M. 7
7a. BIRTHPLACE (State or foreign country) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? MARYLAND	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Baltimore Medical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Center	
13a. LSLAL RESIDENCE (Where deceased lived, if institution Residence before adm.ssion) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY, I.M. TS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last Donald Duke		15. MOTHER'S MAIDEN NAME First Middle Last Frances Duke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address Duke	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GRAM NEG ROD SEPTICEMIA 2750 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) GRAM NEG PYODERMIA AND PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) AGAMMAGLOBULINEMIA					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from MARCH 29, 1969 , to APRIL 8, 1969 , that (I) (we) last saw the deceased alive on APRIL 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles C. Brown, M.D.				22c. DATE SIGNED APRIL 8, 1969	
22d. PHYSICIAN'S NAME (Type) CHARLES C. BROWN				22e. ADDRESS 6701 N. CHARLES STREET	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/12/69		23c. NAME OF CEMETERY OR CREMATORY Greenview Mem. Cem.	
23d. LOCATION (City or Town) (County) (State) Baltimore Md.		24. FUNERAL DIRECTOR THE LASSAHAN FUNERAL HOME			
25a. REG. PRESTIGER APR 10 1969		25b. REG. PRESTIGER APR 10 1969			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

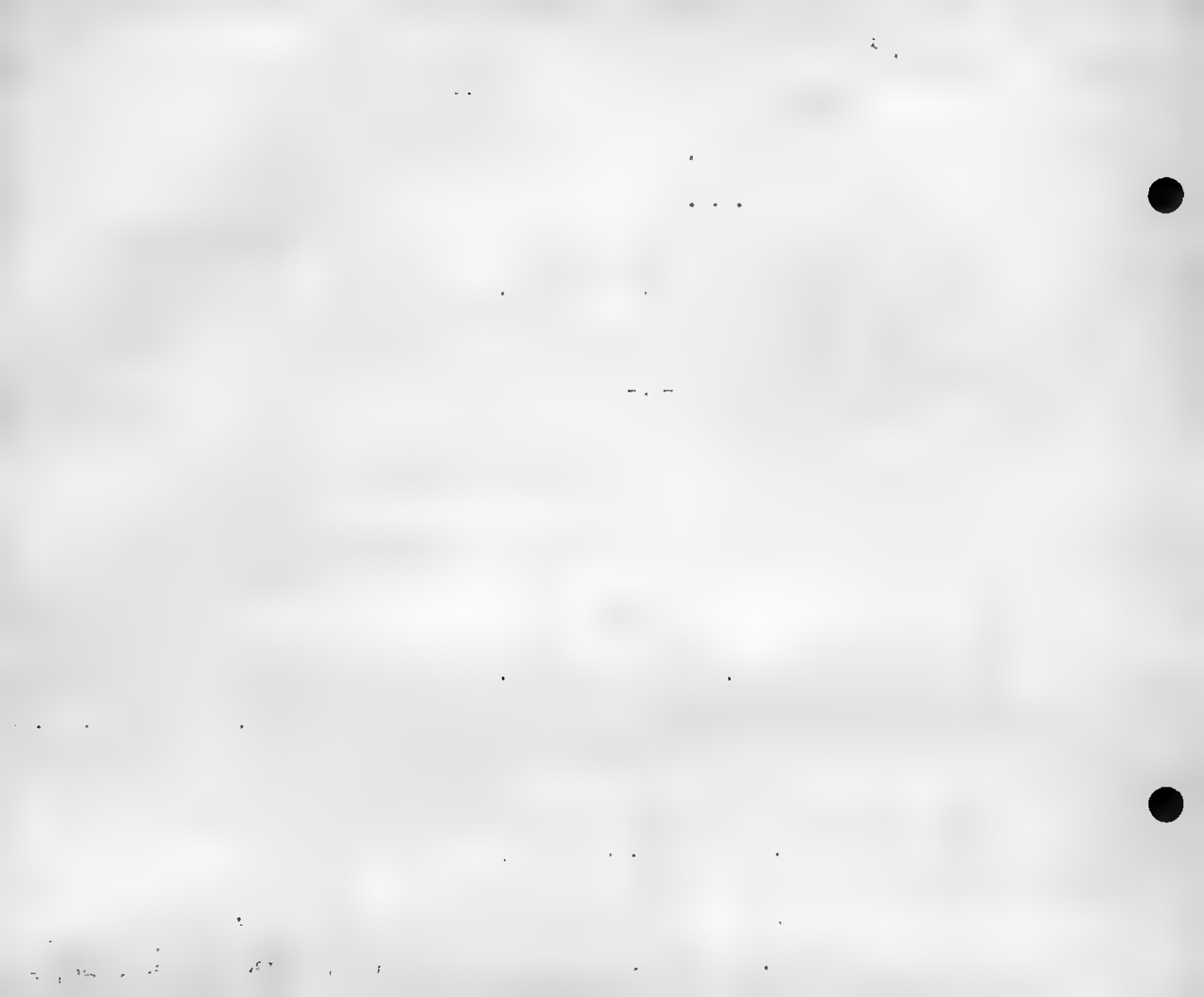
05018

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05010

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF EST. DEATH		Month	Day	Year	2b. HOUR	
CLARA		ELIZABETH	DUNKELBERGER		<input type="checkbox"/> April 11, 1969					7:30A	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	March 6, 1932	37 YRS					Month April Day 11, Year 1969		7:30A	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			2410 Cidermill Road			Manager Farmers Market					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Balto.		Balto.				2410 Cedarmill Road		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Charles			Adam	Roycroft	Catherine			Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			
No			218-26-0615		John Roycroft			2911 Rayshire Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Gunshot wound of head											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. Unk. P.M. 4-11- 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
						Subj. shot by husband who inturn shot himself					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County	State
			Bedroom-Home			2410 Cidermill Rd. Balto.			Balto.	M.D.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Ronald N. Kornblum, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			4/11/69		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			4/14/69		New Cathedral			Baltimore, Maryland			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
Leonard J Ruck Inc. Baltimore, Maryland								DATE APR 14 1969			Charles J. J. J.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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05019

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05011

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR
MARLIN			FOSTER	DUNKELBERGER	April 11, 1969					7:30 A.M.
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER YEAR	IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	1/28/1920		49 YRS	MONTHS	DAYS	HOURS	MIN	Month	Day
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Pa.		USA				Baltimore		Mo.		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Baltimore		2410 Cidermill Road		Auto Mechanic		Auto				
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE		13b COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Balto.		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2410 Cidermill Rd.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Curtis Dunkelberger					Pearl Crowl					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes		WWII		167241520		Blank Funeral Home Sunbury Pa 17801				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) Gunshot wound of head										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
??		4-11- 19 69		Self-inflicted						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
Bedroom-Home		2410 Cidermill Rd.		Balto.		Balto.		M.D.		
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		4/11/69		
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
Burial		4/ 13/69		Millers Crossroads Cem		Sunbury Pa.				
24 FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Leonard J. Ruck Inc. Balto. Md. 21214						DATE APR 14 1969		Charles Judge		



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05020

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05012

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
BRICE				GILBERT	DU VAL	04 Month 29 Day 69 Year			5:45 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		CAU		6-08-29		39 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		U.S.A.				BALTIMORE COUNTY Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON, MARYLAND			GRTR. BALTO. MED. CNTR.			Fire Fighter			County Fire Dept.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Baltimore		Essex 21221			471 Torner Road			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Joseph DuVal						Evelyn Weide					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT			Address			
Yes			Korean		220 24 0360			Wanda DuVal Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CA OF LUNG RIGHT									11 MONTHS		
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from MARCH 29, 19 69, to APRIL 29, 19 69, that (I) (we) last saw the deceased alive on APRIL 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B. K. Choi, M.D.						DEGREE ATTENDING PHYS		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED APRIL 29, 1969	
22d. PHYSICIAN'S NAME (Type) B. K. CHOI						22e. ADDRESS 6701 NORTH CHARLES STREET					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 5/1/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland				
24. FUNERAL DIRECTOR Brzudzinski Funeral Home 1407 Eastern Ave.						25a. REC'D BY REGISTRAR MAY 1 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05021

05013

1 DECEASED NAME (Type or print) JOHN PAUL DWAYER			2a. DATE OF DEATH April 8, 1969			2b. HOUR M			
3. SEX Male		4 RACE White		5. DATE OF BIRTH 2-6-1888		6. AGE (in years last birthday) 81 YRS.		F UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Arbutus		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 1270 Maple Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1270 Maple Avenue	
14. FATHER'S NAME First Middle Last John Paul Dwayer			15. MOTHER'S MAIDEN NAME First Middle Last Sarah R. Turner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 212-05-5161		17. INFORMANT Address Mrs. Lucille C. Walsh, 1228 Stevens Ave. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4124 ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE & PERIPHERAL CIRCULATORY COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (b) DISEASE & PERIPHERAL CIRCULATORY COLLAPSE DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/1/69 , 19 69 , to 4/8/69 , 19 69 , that (I) (we) last saw the deceased alive on 4/8/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. John Shaw				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/9/69	
22d. PHYSICIAN'S NAME (Type) Dr. John Shaw				22e. ADDRESS 5800 Edmondson Avenue, Balto., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-12-1969		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229				25a. RECEIVED BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

10/20/20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05022

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05014

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Mary</i>			First <i>A.</i> Middle <i>Ebberts</i> Last			2a. DATE OF DEATH Month <i>April</i> Day <i>16</i> Year <i>1969</i>			2b. HOUR M					
3 SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>Oct. 21, 1890</i>			6. AGE (In years last birthday) <i>78</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i>			Md		
10. CITY OR TOWN OF DEATH <i>Woodlawn</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>1519 Woodcliff Ave.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>			13b. STATE <i>Baltimore</i>			13c. CITY OR TOWN <i>Woodlawn</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <i>1519 Woodcliff Ave.</i>		
14. FATHER'S NAME <i>Franz Reinhardt</i>			First <i>Franz</i> Middle <i>Reinhardt</i> Last			15. MOTHER'S MAIDEN NAME <i>Marie Boecker</i>			First <i>Marie</i> Middle <i>Boecker</i> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			(If yes give war or dates of service) <i>-----</i>			16b. SOCIAL SECURITY NO. <i>212-05-2715B</i>			17. INFORMANT <i>Mrs. Emma Kemp-1519 Woodcliff Ave. 21228</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>												<i>2-3 days</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Calcific Aortic Stenosis</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>4/12</i> 19 <i>69</i> to <i>4/16</i> 19 <i>69</i> , that (I) (was) last saw the deceased alive on <i>4/12</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>James Nolan</i>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>4/17/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>J. S. NOLAN</i>			22e. ADDRESS <i>Baltimore Md 21229</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>4/19/69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Meadow Ridge Mem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Elkridge Howard Md.</i>					
24. FUNERAL DIRECTOR <i>John T. Stansbury, Sr.</i>			ADDRESS <i>-6411 Windsor Mill Rd.</i>			25a. REC'D BY REGISTRAR DATE <i>APR 21 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Richard Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05023 CERTIFICATE OF DEATH 05015										
1. DECEASED-NAME (Type or print) First Middle Last Estelle H. Edson			2a. DATE OF DEATH Month Day Year 4 - 26 - 69			2b. HOUR 10:25 AM				
3. SEX F		4. RACE W		5. DATE OF BIRTH 8/27/1900		6. AGE (In years last birthday) 68 YRS.		7. UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.				
10. CITY OR TOWN OF DEATH Cotonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3025 Beechfield Ave.	
14. FATHER'S NAME First Middle Last Charles Foster			15. MOTHER'S MAIDEN NAME First Middle Last Margaret Hedinger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b. SOCIAL SECURITY NO. 212-03-8766		17. INFORMANT Mrs. Earl Gable, 302 S. Beechfield Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERNEPHROMA</u> <u>1890</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>wide spread</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>67</u> , to <u>4/26</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>E. KASARI'S, M.D.</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/26/69</u>		
22d. PHYSICIAN'S NAME (Type) <u>E. KASARI'S, M.D.</u>						22e. ADDRESS <u>1301 Frederick Road, Baltimore, Md. 21238</u>				
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>4/29/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crestlawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Howard County, Md</u>		
24. FUNERAL DIRECTOR <u>Witzke, 4101 Edmondson Ave., 21229</u>						25a. REC'D BY REGISTRAR <u>APR 29 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15-14
45M - 1-69

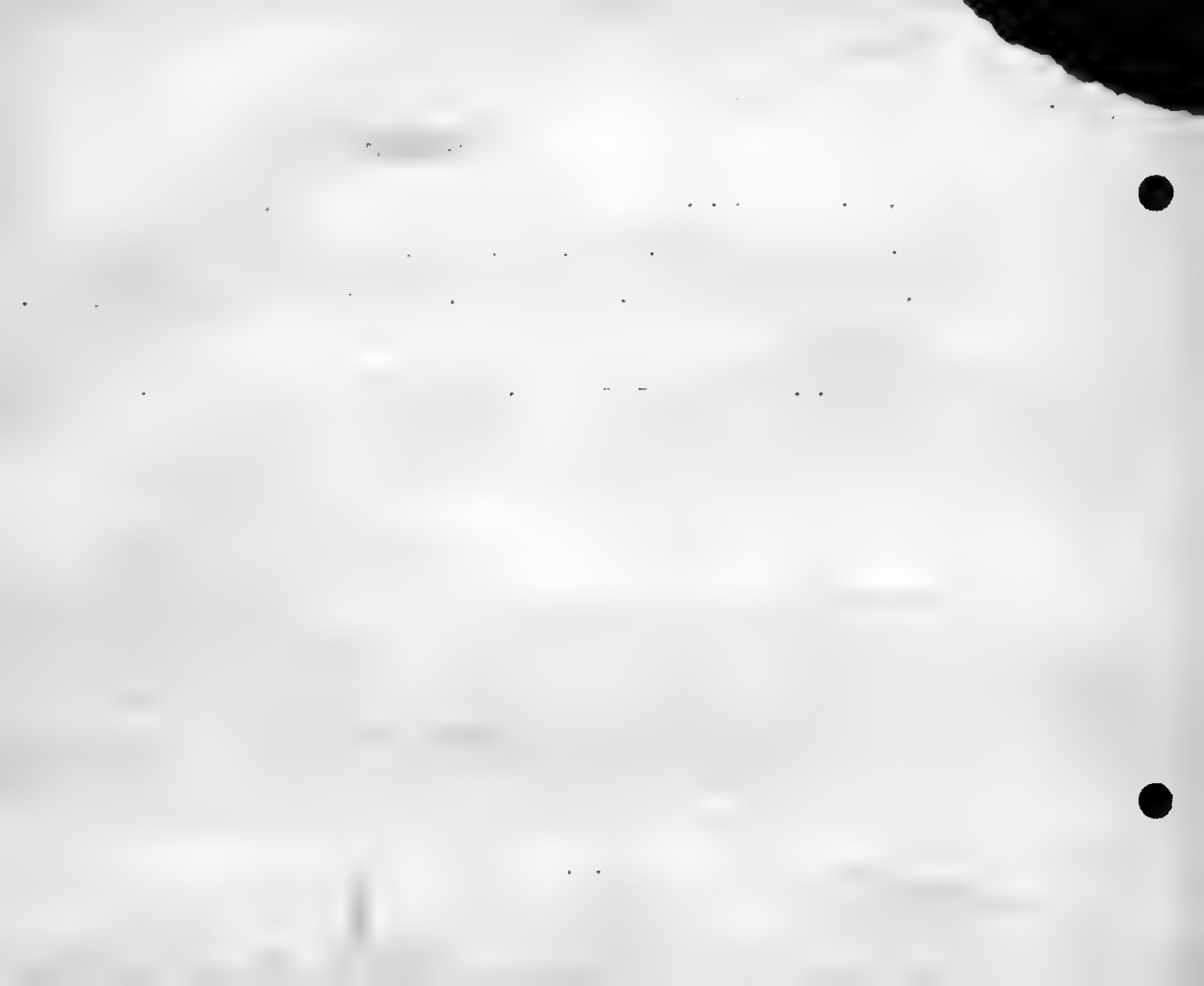
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05024

CERTIFICATE OF DEATH

05016

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Harry,				Farber	Month Day Year April 25 1969		P M	
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR	
Male	White		[REDACTED]		73 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
RICHMOND, VA.		U.S.A.				Balto.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Balto.		Balto. Cnty. Gen. Hosp.		PLUMBER		CONSTRUCTION		
13a. USUAL RESIDENCE (Where deceased lived; if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.		Balto.		Balto.		YES		3705 1/2 MARION R AVE.
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
CHARLES		FARBER		IDA SCHERR				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
YES		W.O. 11 ARMY 213-03-7263		MR. IRWIN FARBER, 8539 LUCERNE RD., #21133				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASBESTOSIS</u>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-23-69, to 4-23-69, that (I) (we) saw the deceased alive on 4-23-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <u>Gregorio Marfori, MD</u> DEGREE					ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-23-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Gregorio Marfori, M.D.</u>					22e. ADDRESS <u>BOGH House Doctor</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		4-25-69		HEBREW YOUNG MEN		BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> ADDRESS					25a. REC'D BY REG. STR. DATE <u>APR 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

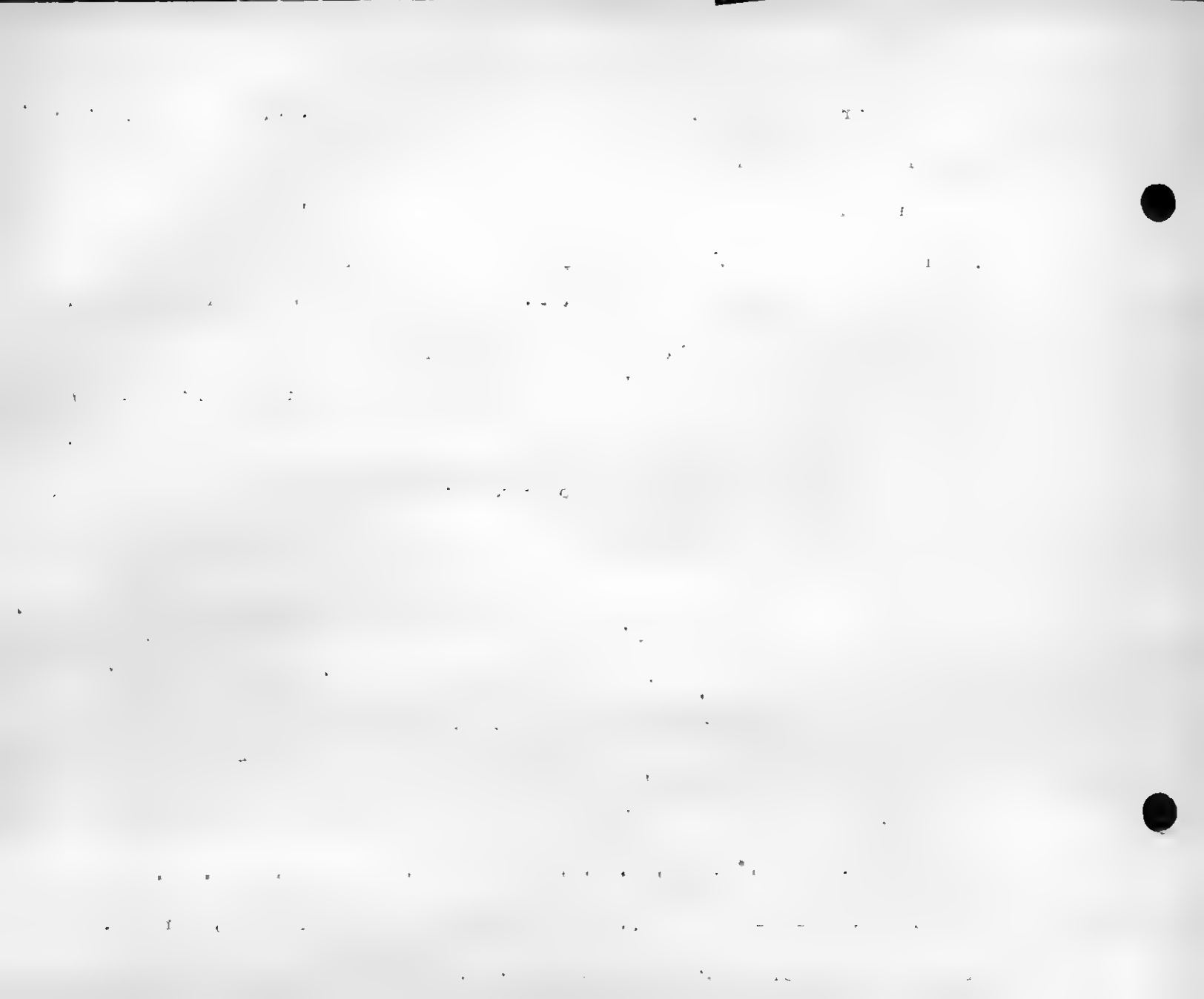


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115 (4)
30M REV. 1-68

05025										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05017									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Cora E. Feaster										Apr. 26 1969										9:25AM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.														
Female			White			9-26-1875			93			MONTHS			DAYS			HOURS			MIN								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
West Virginia			USA						Baltimore										Md.										
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Baltimore					Shangri La Nursing Home					At Home																			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS?					13d. STREET AND NUMBER														
MD					Balto					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					4702 Springdale Ave.														
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Charles Culler					Effie Feaster																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
NO					NO					Helen Dent - 2317 Birch Drive # 21207																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:															1 hour														
IMMEDIATE CAUSE (a) Coronary occlusion																													
DUE TO, OR AS A CONSEQUENCE OF																													
Arteriosclerotic cardiovascular disease															20 years														
DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
XXXXXXX					XXXXXXXXXXXXXXXXXXXXXXX					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					XXXXXXXXXXXXXXXXXXXXXXX														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
					P.M. 19					XX																			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)					21f. LOCATION Street or RFD No. City or Town County State																			
					XXXXXXXXXXXX					XX																			
22a. I certify that (I) (we) attended the deceased from _____, 1950, to April, 1969, that (I) (we) last saw the deceased alive on April 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
Millard T. Traband, Jr. M.D.										4/28/69																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
Millard T. Traband, Jr. M.D.										1811 N. Rolling Rd. Balt. Md. 21207																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					4-28-69					St. Paul's Lutheran Cem					Jefferson, Maryland														
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
Armecost Funeral Chapel-4600 Liberty Hts.										APR 30 1969					J. L. ...														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
05026																	
CERTIFICATE OF DEATH																	
05018																	
1. DECEASED NAME (Type or print)			First Alice			Middle L.			Last Ferrens			2a. DATE OF DEATH Month 4 Day 5 Year 1969			2b. HOUR 9:55 MIN A		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 9/6/1882			6. AGE (In years lost birthday) 86 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Harford Co., Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.								
10. CITY OR TOWN OF DEATH Glendale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6709 Tweedbrook			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker			12b. KIND OF BUSINESS OR INDUSTRY								
13a. U.S. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Balto			13c. CITY OR TOWN Glendale			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 7609 Tweedbrook Rd.					
14. FATHER'S NAME First Charles			Middle Ridgley			Last Mary			15. MOTHER'S MAIDEN NAME First R. Mac Dow			Middle R. Mac Dow			Last R. Mac Dow		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO 218-32-0456			17. INFORMANT Edith J. Ferrens			Address 6709 Tweedbrook Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Secondary anemia DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 15 yrs. 1 yr.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from April 5, 1967 to April 5, 1969 , that (I) (we) last saw the deceased alive on March 29, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Lloyd E. Saylor, MD			22c. DATE SIGNED Apr. 7, 1969			22d. PHYSICIAN'S NAME (Type) Dr. Lloyd E. Saylor											
22e. ADDRESS 3902 Greenmount Ave																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/8/1969			23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery			23d. LOCATION (City or Town) (County) (State) Woodlawn Balto. Md.								
24. FUNERAL DIRECTOR Mitchell Wiedefeld Home			ADDRESS 6500 York Rd.			25a. REC'D BY REGISTRAR APR 9 1969			25b. REGISTRAR'S SIGNATURE M. J. Jones								

FOR STATE
HEALTH DEPT.

05027

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05019

1. DECEASED NAME (Type or Print) MARGARET M. FETZ			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day Year APR. 20 1969			2b. HOUR 8:45 AM		
3. SEX F	4. RACE W	5. DATE OF BIRTH 10/29/99	6. AGE (In years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 4 Day 20 Year 1969		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.		
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1417 EASTERN			12a. USUA. OCCUPATION (Kind of work done during most of work'ng life, even if ret red.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1417 EASTERN
14. FATHER'S NAME First Middle Last HENRY CUMBERLAND			15. MOTHER'S MAIDEN NAME First Middle Last MARGARET KELLNER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNIK (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT MICHAEL F. FETZ			ADDRESS ABOVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CA. of Right Breast 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis, Brain, liver etc DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day Year May 1969 HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE M.B. Davis		EXAMINER'S NAME (Type) M.B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/22/69		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/23/69		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART		23d. LOCATION (City or Town) (County) (State) BALTO. MD.		
24. FUNERAL DIRECTOR J.G. CONNELLY SONS				ADDRESS 300 MACO		25a. REC'D BY REGISTRAR APR 24 1969		25b. REGISTRAR'S SIGNATURE J. Connelly

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The following certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1

05028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05020

1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
ALFRED THOMAS FINNEY						APRIL Month 2 Day 1969 Year			1:30 M					
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		NEGRO		May 2, 1892			76 YRS.		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
VIRGINIA			U.S.A.						BALTIMORE			Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD			ADMINISTRATION HOSPITAL			MINISTER								
13a USUAL RESIDENCE (Where deceased lived if institution admission) - STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
MARYLAND						BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1308 Rutter Street		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
GEORGE			FINNEY			NORA			--			--		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO			7 INFORMANT			Address					
YES			WW-1			217 09 7322			Clinical Recds VA Hospital, Fort Howard, Md.					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident										1 MONTH				
4369 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19											
21d INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION			City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work						Street or R.F.D. No								
22a. I certify that (this hospital) attended the deceased from Mar 31, 1969, to April 2, 1969, that (X) (we) last saw the deceased alive on April 2, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (not) view the body after death.														
22b SIGNATURE			22c DATE SIGNED											
Peter V. Juvan			4 2 69											
22d PHYSICIAN'S NAME (Type)			22e ADDRESS											
PETER V. JUVAN, M. D.			VA Hospital, Fort Howard, Md.											
23a BURLIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
BURIAL			4-7-69			BALTIMORE NATIONAL CEMETERY			BALTIMORE MARYLAND					
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE								
Phillips Funeral Home			APR 8 1969			Charles Judge								
1727 N. Monroe St.														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
05029					CERTIFICATE OF DEATH					05021				
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR		
Margarette			Marie		Fisher		4 Month 16 Day 69 Year			12:50M				
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		12/1/27			41 YRS.		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		8 NEVER MARRIED		9 COUNTY OF DEATH						
Virginia		U.S.A.		WIDOWED		DIVORCED		Baltimore Md						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Towson			Greater Balto. Med. Center			Clerk			Industrial					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Md			Balto		Towson		YES NO		107 E. Burke Ave					
14. FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last		
George L.			NEELY		KATHERINE		BURKE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			107 E. Burke Ave			Towson Md		
No			220 24 1578			William E. Fisher								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) _____														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) _____														
DUE TO, OR AS A CONSEQUENCE OF														
stating the underlying cause last. _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES NO			Yes					
21a. ACCIDENT WAS UNDERLYING			21b TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M.											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No. City or Town County State								
While at work Not while at work														
22a. I certify that (I) (this hospital) attended the deceased from 3/21, 1969, to 4/16, 1969, that (I) (we) lost saw the deceased alive on 4/15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE						DEGREE			ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.			22c. DATE SIGNED		
John E. Adams												April 16, 1969		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS								
John E. Adams, M. D.						6701 N. Charles St., Baltimore, Md. 21204								
23a BURIAL, CREMATION, or other disposal (Specify)			23b. DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Burial			4-19-69			David Ridge			Balto Md					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Higinbottom-Slack			Ellis City, Md			APR 21 1969			V. L. L. L. L.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit page please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05030										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										0502c	
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR	
Fleming S. Ford										April 22, 1969										12:15 PM	
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			7. UNDER 1 YEAR			8. UNDER 24 HRS						
male			white			March 20, 1893			76 YRS.			MONTHS			DAYS						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH												
Va.			U. S.						Baltimore Md.												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY												
Catonsville			SPRING GROVE STATE HOSP.			printer															
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER									
Md.			Pr. Geo.			Brsdbury Park			YES <input type="checkbox"/> NO <input type="checkbox"/>			2211 Gaylord Drive									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																		
John S. Ford			Louella Jones																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT															
yes 1917-18			223-09-5212			Records: SPRING GROVE STATE HOSPITAL															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4270										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u>																					
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?												
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)															
			HOUR A.M. Month Day Year P.M. 19																		
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION															
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or RFD No. City or Town County State															
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Sept. 5, 1963</u> to <u>April 22, 1969</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 22, 1969</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I)</u> <u>(we)</u> <u>(did not)</u> view the body after death.																					
22b. SIGNATURE			22c. DATE SIGNED																		
<u>Rafael H. Marin</u>			4-23-69																		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																		
Rafael H. Marin, M.D.			SPRING GROVE STATE HOSPITAL			Baltimore, Maryland 21228															
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)												
Burial			4/28/69			BALTO. NATIONAL Cem			BALTO. Md.												
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE															
E. B. Mac Nabb			301 Frederick Rd 21228			APR 25 1969			<u>Charles Judge</u>												

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05031

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05025

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 4/14/ 19 69			2b. HOUR 6:30 P. M.			
LILLIAN			M.			FORLIFER						
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR P. M.	
female	white	April 24, 1925	43 YRS					April 14, 19 69			6:45 P. M.	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Fullerton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4920 Hazelwood Avenue			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Self-Employed-Waste			12b. KIND OF BUSINESS OR INDUSTRY Oil Business			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 4920 Hazelwood Avenue
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
Edward Thomas			Leonard			Marie			Cole			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-20-0799			17. INFORMANT Miss Sandra M. Forlifer			ADDRESS (Same)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Werner U. Spitz, M.D.						22b. DATE SIGNED 4/15/69			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/18/69.			23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR DATE APR 17 1969			25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05032

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05024

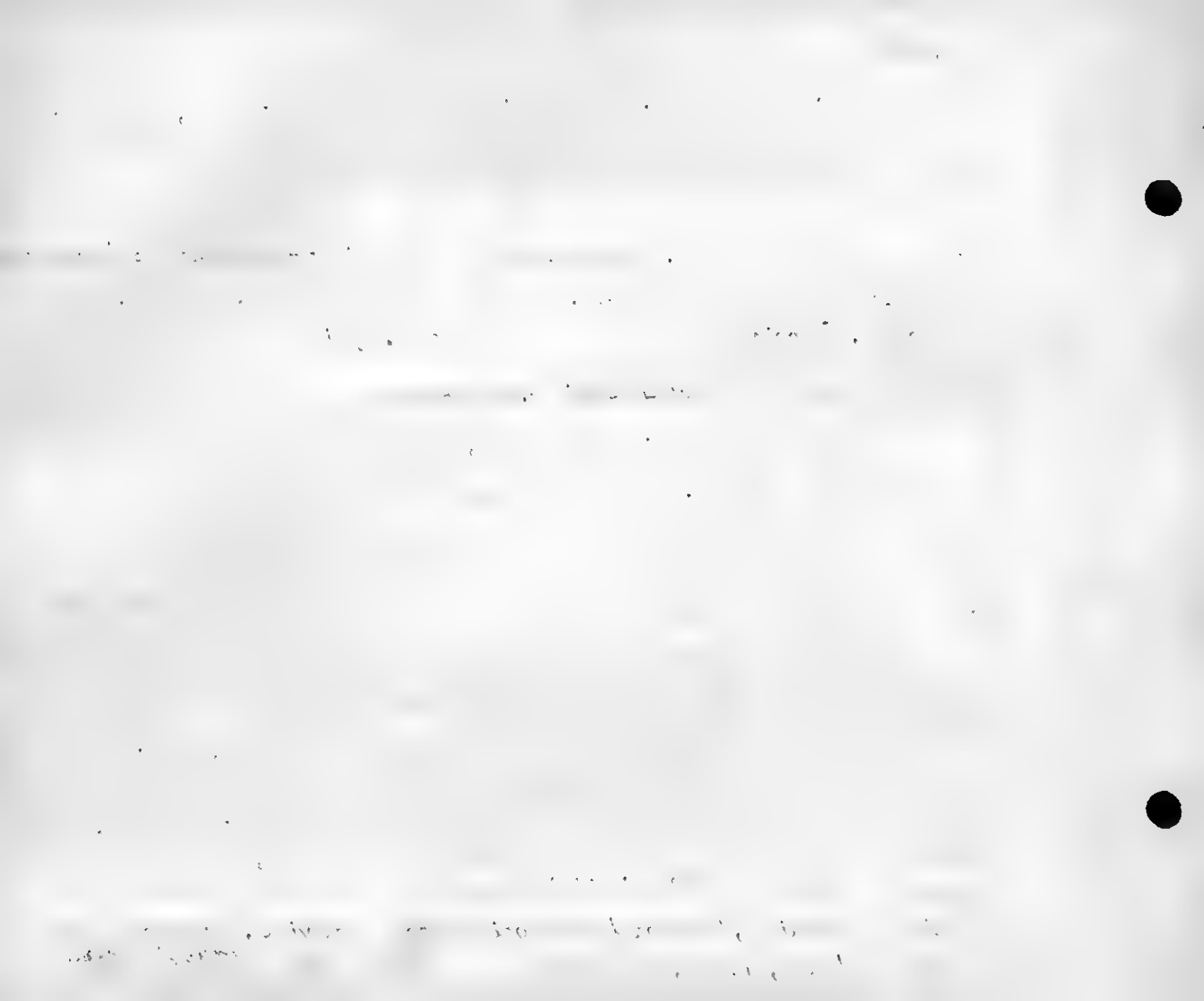
1. DECEASED-NAME (Type or print) First Middle Last Elsie Mae Foxwell			2a. DATE OF DEATH Month Day Year April 3 1969			2b. HOUR 8:25	
3. SEX F.		4. RACE W.		5. DATE OF BIRTH Oct. 28, 1890		6. AGE (In years lost birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1114 Sleepy Dell Court		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 1114 Sleepy Dell Court		14. FATHER'S NAME First Middle Last James Hall		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Daugherty			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no or unknown? NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-09-2876		17. INFORMANT Address Mrs Virginia E. Lewis 1114 Sleepy Dell			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Breast DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 5 1/2 yr							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 1/2 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of Breast & metastases to liver & bone							
19a. DATE OF OPERATION Feb 20, 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 1953 to Apr 3, 1969 , that (I) last saw the deceased alive on Mar 15, 1969 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.							
22b. SIGNATURE N.R. Freeman				22c. DATE SIGNED 4/4/69		22d. PHYSICIAN'S NAME (Type) Norman R. Freeman M.D.	
22e. ADDRESS 11 West 29th Street							
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 4/5/69		23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or Town) (County) (State) Woodlawn Md.	
24. FUNERAL DIRECTOR ADDRESS Henry Sander & Sons Inc.				25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



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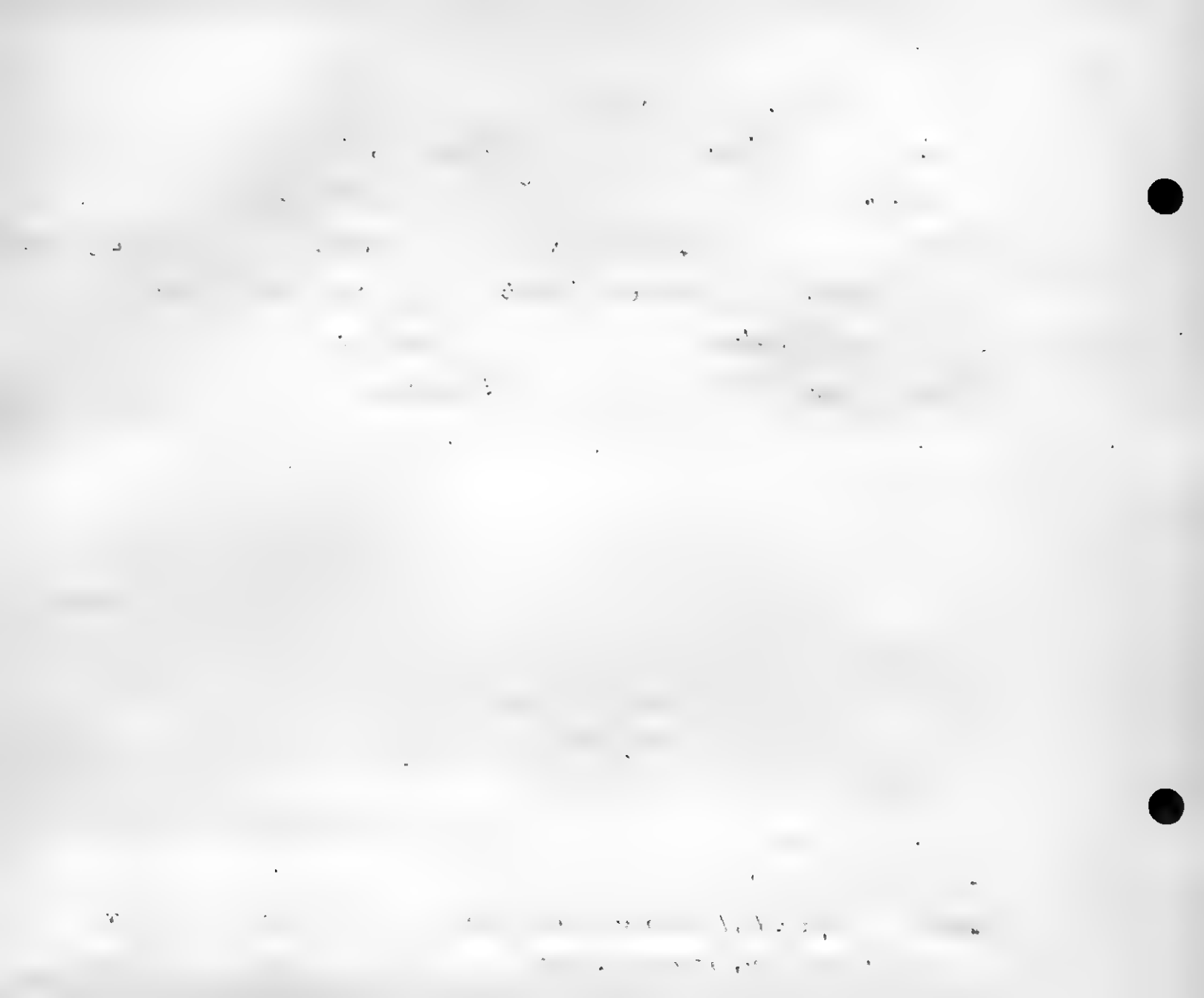
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05033		CERTIFICATE OF DEATH						05025			
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
John			L. Francis			April 4, 1969			5:25 A		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. F. UNDER 1 YEAR		
Male		White		5-9-1898			70 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland			USA				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson			St. Joseph Hospital			Retired - carpenter			self employee		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Baltimore Co.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1801 E. Joppa Rd. 21234		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John C. Francis			Mary M. Eppig								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address						
No			None		213-05-2624 Family records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, Massive											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last.											
(b) Generalized Arteriosclerosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from March 30, 1969, to April 4, 1969, that (I) (we) last saw the deceased alive on April 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
Gualberto Gokim, Jr.									April 4, 1969		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Gualberto Gokim, Jr. M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		April 7, 1969		Moreland Memorial Park			Parkville, Maryland				
24. FUNERAL DIRECTOR						25a. REC'D BY REG. STR.			25b. REG. STR. SIGNATURE		
John Burns' Sons, Towson, Maryland						APR 10 1969			Charles Judge		



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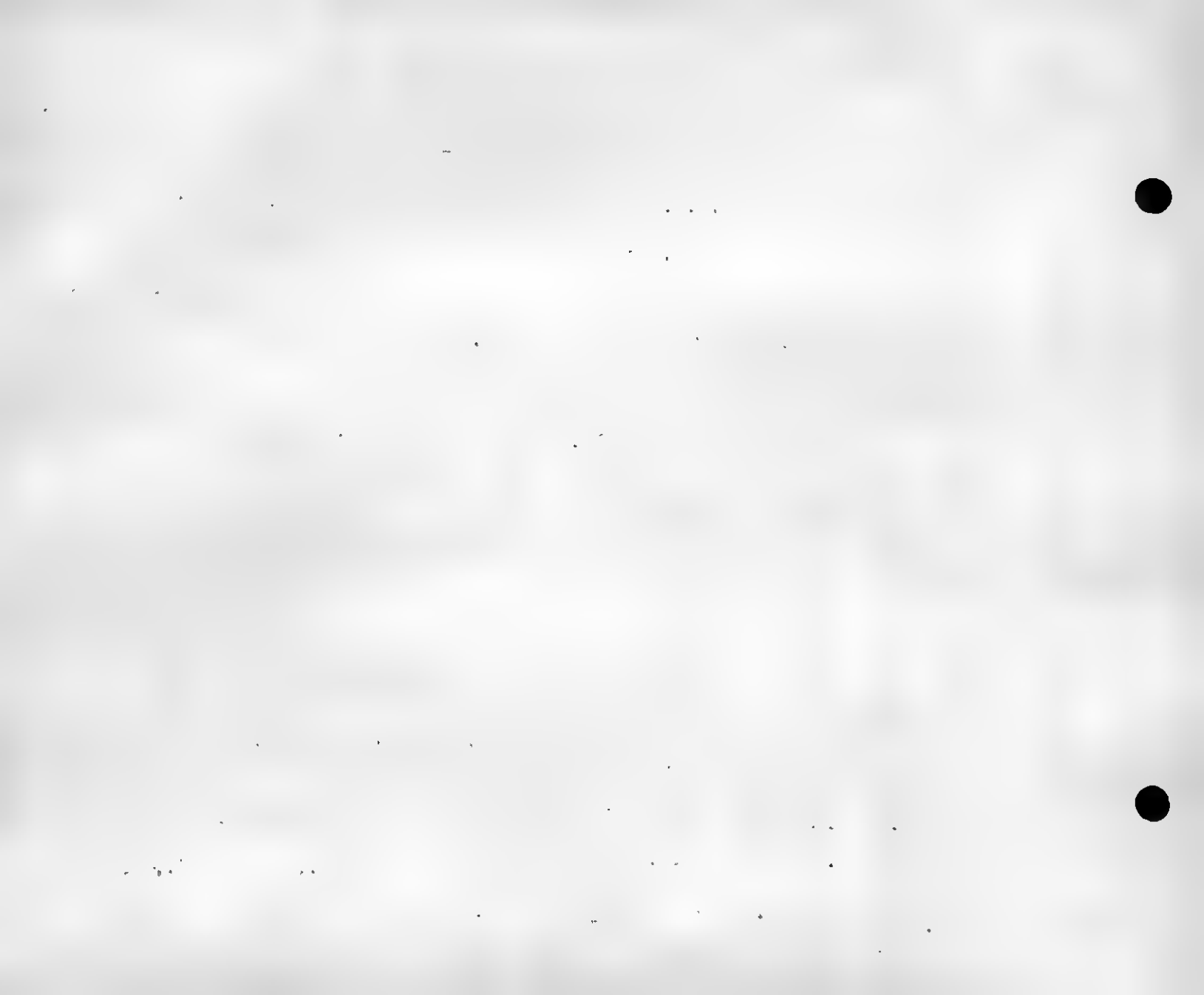
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05034		CERTIFICATE OF DEATH						05026	
1 DECEASED-NAME (Type or print) <i>CLARENCE</i>			First Middle Last <i>Ellmer FREELAND</i>			2a. DATE OF DEATH Month <i>12</i> Day <i>19</i> Year <i>1969</i>			2b. HOUR <i>3:15</i> M
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>November 21, 1898</i>			6 AGE (in years last birthday) <i>70</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md			
10 CITY OR TOWN OF DEATH <i>Phoenix</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Paper Mill Road</i>			12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired) <i>Compositor</i>		12b. KIND OF BUSINESS OR <i>Self Employed</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Phoenix</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Paper Mill Road</i>	
14 FATHER'S NAME First Middle Last <i>Joseph FREELAND</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Angela Nace</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>			16b. SOCIAL SECURITY NO. <i>None</i>		17 INFORMANT <i>Family records</i> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A. A. C. V. disease</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1938</i> , to <i>4/12</i> , 1969, that (I) (we) last saw the deceased alive on <i>4/10/69</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>A. M. France</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>				22e. ADDRESS <i>PARKTON, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 15, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Poplar Grove Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Cockeysville, Maryland</i>			
24 FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>APR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Young</i>			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mamie			Frieese			Month Day Year April 12 69			5.20 PM
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		8-23-1886		82 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland			U.S.A.				Baltimore Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Towson			St. Joseph Hospital			HOUSE WIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Baltimore		Essex		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		410 Wamper Rd., -21224
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
CARL ROCKEL			MARY THEIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, np, or unknown			16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
NONE					WM. P. FRIESE ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - Pulmonary Thrombosis									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3/24/1969 to 4/12/1969, that (I) (we) last saw the deceased alive on 4/12/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Banderas, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-12-69	
22d. PHYSICIAN'S NAME (Type) J. Banderas M.D.						22e. ADDRESS 7620 York Rd., Towson Md., 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			4/15/69		ZION LUTHERAN		BALTO. MD		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J.G. CONNELLY SONS 300 MACE					DATE APR 15 1969		Charles Judge		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
05036		CERTIFICATE OF DEATH						05028				
1 DECEASED-NAME (Type or print) MARIE			First E.		Middle FULLER		Last		2a. DATE OF DEATH April 19, 1969		2b. HOUR 11 A M	
3 SEX Female			4 RACE White			5. DATE OF BIRTH 12-3-1902			6 AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md			
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Summit Nursing Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Woodlawn			13d ASIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6725 Kincheloe Avenue 21207	
14 FATHER'S NAME Joseph Serra			First Middle Last			15 MOTHER'S MAIDEN NAME Lillian (Unknown)			First Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b SOCIAL SECURITY NO 220-07-9851A			17 INFORMANT Address Mr. Thomas J. Fuller, 6725 Kincheloe Avenue						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Emphysema 4-11-X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obstructive Airway Disease DUE TO, OR AS A CONSEQUENCE OF (c) (Bronchitis)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Lymphosarcoma												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A M Month Day Year P M 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State						
22a I certify that (I) (this hospital) attended the deceased from 1-3, 1959 , to 4-19, 1969 , that (I) (we) last saw the deceased alive on 4-18, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE John F. Schaefer			DEGREE Dr. John F. Schaefer			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED 4-20-69			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS 401 Random Road, Baltimore, Maryland									
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 4-23-1969			23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery			23d LOCATION (City or Town) (County) (State) Woodlawn, Maryland			
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			ADDRESS			25a RECEIVED BY REGISTRAR DATE APR 23 1969			25b REGISTRAR'S SIGNATURE Harold A. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First WILLIAM		Middle GAYLORD		Last GAYLORD		2a. DATE OF DEATH Month 4 Day 30 Year 89		
3. SEX MALE		4 RACE NEGRO		5 DATE OF BIRTH 12/15/96			6 AGE (in years last birthday) 72 YRS.		2b HOUR 7:15AM		
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			
10 CITY OR TOWN OF DEATH FORT HOWARD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VET ADM. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Steel Worker			12b. KIND OF BUSINESS OR INDUSTRY Steel Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE			13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1324 Ellwood Avenue	
14. FATHER'S NAME First ELLIS Middle GAYLORD Last GAYLORD			15. MOTHER'S MAIDEN NAME First SUSIE Middle THORPS Last THORPS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES (If yes, give year or dates of service) WW I			16b. SOCIAL SECURITY NO 213 09 30 95			17 INFORMANT CLIN. RECORDS, VA HOSP. FT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION											
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HEMORRHAGE											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROTIC HEART DISEASE. DIABETES MELLITUS, CLINICAL											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that he (this hospital) attended the deceased from 4/17/69 , 19____, to 4/30/69 , 19____, that he (we) last saw the deceased alive on 4/30/69 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.											
22b. SIGNATURE John D. Talbert, M.D.						DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/30/69	
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.						22e. ADDRESS VAH FORT HOWARD, MARYLAND					
23a. BURIAL, CREMATION, or other disposition BURIAL			23b. DATE May 1 1969			23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR ELLIOTT FUNERAL HOME						ADDRESS 1129 W. Caroline St.		25a. REC'D BY REGISTRAR 1969		25b. REGISTRAR'S SIGNATURE John D. Talbert	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED			2b HOUR
GEORGE			GEORGANDIS			April 18, 1969			7:15 MA
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years, last birthday)	7 IF UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD			2d HOUR
Male	White	March 13, 1912	56-57 RS			April 18, 1969			7:15 MA
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Greece		U.S.A.				Baltimore Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Dundalk			4029 North Point Blvd.			Owner North Star Inn			
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b CITY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Baltimore		Dundalk	YES <input type="checkbox"/> NO <input type="checkbox"/>		4029 North Point Blvd.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
Simon			Georgandis			Despina ?			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		
No			216-32-8127		Mrs Grace Georgandis		Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of head									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost									
DUE TO OR AS A CONSEQUENCE OF (b)									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
		A.M. April 18, 1969		Shot during robbery					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
		Building		4029 North Point Blvd.		Balto.		M.D.	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				4/18/69			
Ronald N. Kornblum, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		4/21/69		Greek Orthodox		Baltimore, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Leonard J Ruck Inc Baltimore, Maryland						DATE APR 21 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

105039

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05031

1. DECEASED NAME (Type or print) LILLIAN		First Middle Last GERMAN		2a. DATE OF DEATH Month Day Year April 2 1969		2b. HOUR 5:46 A.					
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH Oct. 29, 1888		6. AGE (In years lost birthday) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holly Hill Manor		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland COUNTY Frederick		13b. CITY OR TOWN Thurmont		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rd. #1 Box 34					
14. FATHER'S NAME First Middle Last Thomas A. German		15. MOTHER'S MAIDEN NAME First Middle Last Laura V. Timmons									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 220-30-3468		17. INFORMANT Address Mrs. Mildred Hudson 2708 Grindon Avenue #14							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A severe attack heart failure (anoxia) DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus (14 yrs) CONDITIONS, if only, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1952 to April 1969 , that (I) (we) lost saw the deceased alive on Mar. 29 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wm. H. Kammer, Jr.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/2/69					
22d. PHYSICIAN'S NAME (Type) Dr. William H. Kammer, Jr.				22e. ADDRESS 6011 York Road, Balto, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/5/69.		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland					
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Baltimore, Md.-14				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05040		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05032	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print) CAMILLE L		First L		Middle B. BBS		Last	
2a DATE OF DEATH Month 4 Day 7 Year 69		2b. HOUR 6:20 A.M.		3 SEX F		4. RACE W	
5. DATE OF BIRTH 7-7-1880		6 AGE (in years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) CELESTOWN KY		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALT. CO.	
10 CITY OR TOWN OF DEATH BALT. Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6325 Boxwood Rd.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE D.C.		13b. COUNTY D.C.		13c. CITY OR TOWN WASH DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4458 RESERVOIR Rd		13f. N.W. WASH		14. FATHER'S NAME First EDWARD Middle C. Last HOPPER		15. MOTHER'S MAIDEN NAME First MARY K. Middle BALLEY Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 578-62-3904		17 INFORMANT MISS BARBARA C. BBS		Address D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mm		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1. Hypostatic pneumonia 2. Pulmonary emphysema			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 			
22a. I certify that (I) (this hospital) attended the deceased from June , 19 68 , to April 7 , 19 69 , that (I) (we) last saw the deceased alive on April 6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Edward F. Cotter M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 7, 1969	
22d. PHYSICIAN'S NAME (Type) EDWARD F. COTTER		22e. ADDRESS 827 Linden Ave, Balto. Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-9-1969		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.		ADDRESS 8130 WISC. AVE. N. W. WASH. D. C. 20018		25a. REC'D BY REGISTRAR DATE APR 14 1969		25b. REGISTRAR'S SIGNATURE Richard J. Judge	



TO HOSPITAL OF ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Harry Goldfadim			2a. DATE OF DEATH 4 Month 1 Day 69 Year			2b. HOUR 4:20 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3-25-1887		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital state address) Balto. Co. Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) PROPRIETOR		12b. KIND OF BUSINESS OR INDUSTRY FURNITURE STORE			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Balto		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3624 Templar Rd.	
14. FATHER'S NAME First Middle Last DAVIS G			15. MOTHER'S MAIDEN NAME First Middle Last MIRIAM ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 110-10-0199A		17. INFORMANT Address MRS. BEATRICE GOLDFADIM, 3624 TEMPLAR ROAD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular arrest (Cardiac arrhythmia) 4 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 MIN YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-1 , 19 69 , to 4-1 , 19 67 , that (I) (we) last saw the deceased alive on 4-1 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Angelita Topacio				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-1-69			
22d. PHYSICIAN'S NAME (Type) ANGELITA TOPACIO				22e. ADDRESS 819M					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-2-69		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH BETH ISRAEL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR DATE APR 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Item #7 taken from prev. birth certificate												
05042												
05034												
1. DECEASED NAME (Type or print) CHARLES JR. BENNETT GOLDSBOROUGH						2a. DATE OF DEATH Month 4 Day 20 Year 69			2b. HOUR M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 8/21/57			6. AGE (In years last birthday) 1 YRS		7. UNDER 1 YEAR MONTHS DAYS 		8. UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH JOHNS HOPKINS Baltimore Md.						
10. CITY OR TOWN OF DEATH Owings Mills			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ROSEWOOD STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b. KIND OF BUSINESS OR INDUSTRY 			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.			13b. COUNTY PG			13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3105 Parkway Terrace Dr.		
14. FATHER'S NAME First CHARLES Middle BENNETT Last GOLDSBOROUGH				15. MOTHER'S MAIDEN NAME First NELLI Middle LINDA L Last ISH GOLDSBOROUGH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. none			17. INFORMANT Charles B. Goldsborough, Sr. Address 3105 Parkway Terrace Drive, Apt. 6						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Cerebral defect. DUE TO, OR AS A CONSEQUENCE OF (c) Hypoxic Encephalopathy.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State 								
22a. I certify that (this hospital) attended the deceased from Jan. 29, 1969 , to April 20, 1969 , that (we) last saw the deceased alive on April 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Massoud Kaye						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Md. Owings Mills				
22d. PHYSICIAN'S NAME (Type) MASSOUD KAYE						22e. ADDRESS Rosewood State Hospital, Box 137						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/23/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.						
24. FUNERAL DIRECTOR R. L. Wilhelm, Suitland, Md.		25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE William Under								



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

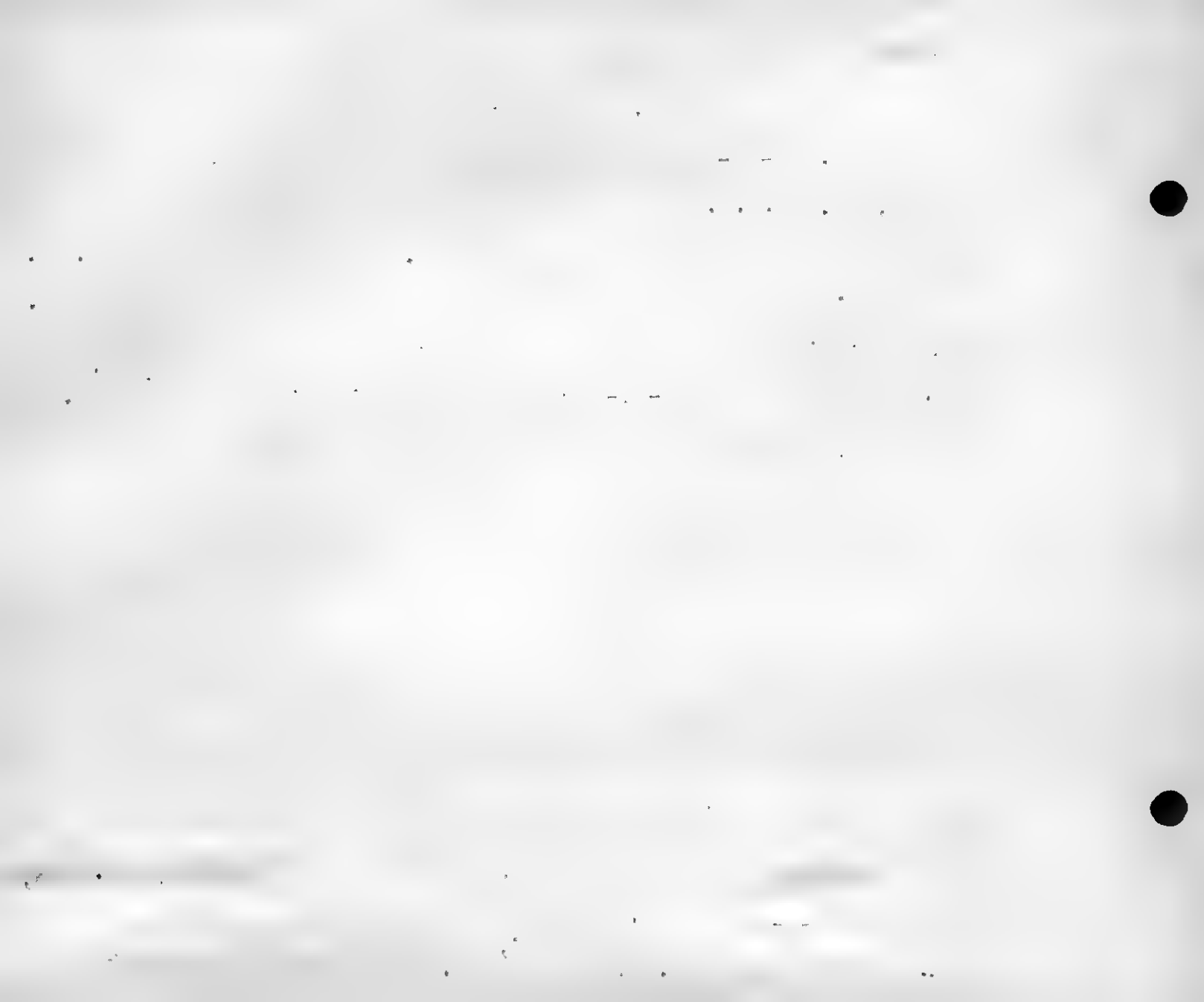
05043

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05035

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH: ESTI MATED		Month		Day		Year		2b. HOUR	
Anthony		A.		Golembieski				4		7		19		69		4/18	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
Male	Cau.	1-11-04		65 YRS		MONTHS		DAYS		4		7		1969		4/18	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH											
Balto., Md.		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Dundalk		203 Willow Spring Rd.		Beth. St.													
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Md.		Balto		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		203 Willow Spring Rd.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
John Golembieski (Deceased)								Lillian ? (Deceased)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No.		213-07-7898		Catherine Golembieski		Spring Rd.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		PART 1 DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				Carcinoma of Lung				31									
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
CAUSE OF DEATH		HOUR A.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Theodore C. Patterson M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED							
EXAMINER'S NAME (Type)		Theodore C. Patterson M.D.		ADDRESS (Street, city, town, or county)		3427 Dundalk Ave.,											
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. NAME OF CEMETERY OR CREMATORY		23c. LOCATION (City or Town)		(County)		(State)									
Burial		Holy Rosary Cemetery		Dundalk, Maryland													
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
John M. Weber & Sons Inc.		401, S. Chester St.		APR 9 1969		John M. Weber & Sons Inc.											



FOR STATE HEALTH DEPT.

05044

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05036

1 DECEASED-NAME (Type or Print)			First	Middle	Lost	2a DATE KNOWN OF DEATH			2b HOUR
Irvin Baxter Gorman						MAY 18 1969			10:25 AM
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7 UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	2d. HOUR
M	W	1/26/91	78 YRS	MONTHS DAYS		HOURS MIN		April 8 Year 1969	M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		U.S.A.				Baltimore			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Towson			St. Joseph Hospital			Dairy			Dairy
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?
Md.			Baltimore						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			21212
William G. Gorman			Frances E. Evans			208 D Rodgers Forge			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS
World War I						Nellie H. Gorman - 208 Rodgers Forge			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100									30 days
DUE TO, OR AS A CONSEQUENCE OF									2+ yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			4/8/69			
			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or town) (County) (State)
Burial			4/11/69			David Ridge Cem			Pikesville, Md.
24. FUNERAL DIRECTOR			25a. DATE BY REFERRAL			25b. APPROVED BY			
Wm J. Tichner-Sons Balto, Md.			APR 10 1969			APPROVED BY			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit when please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV 1-68

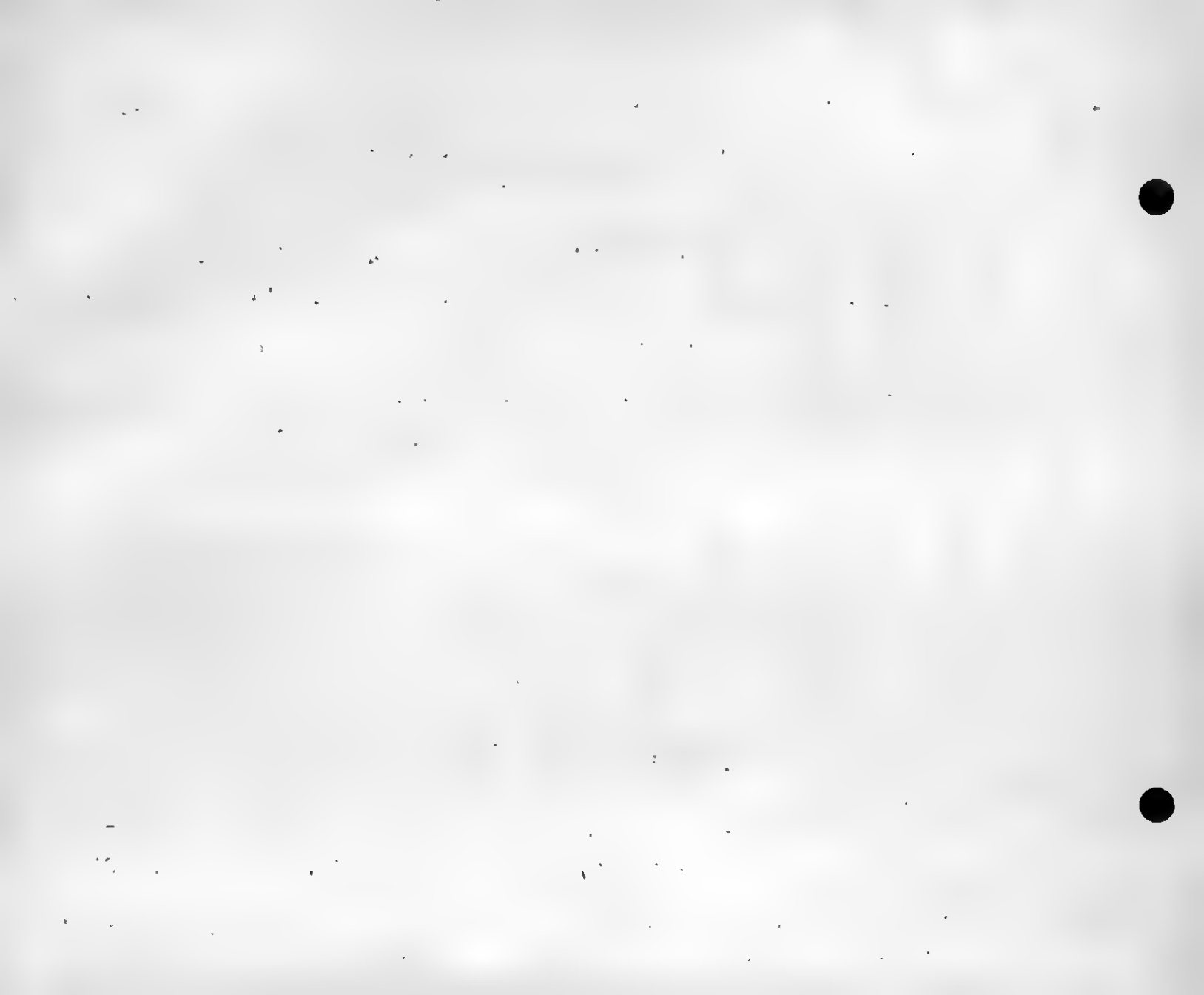
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) John			First Middle Last D. Gorman			2a DATE OF DEATH Month Day Year April 16 1969		2b HOUR 8:45 PM	
3. SEX Male		4. RACE White		5 DATE OF BIRTH 3/4/1986		6 AGE (In years last birthday) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (State or foreign country) Baltimore Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stella Maris Hospice			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) R.R. Conductor		12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Baltimore		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2515 Guilford Ave.	
14. FATHER'S NAME First Middle Last Michael Gorman			15 MOTHER'S MAIDEN NAME First Middle Last Mary Devan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown			16b. SOCIAL SECURITY NO. 717-07-8926		17 INFORMANT Stella Maris Hospice		Address Towson, Md. 21204		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebrovascular accident -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic bronchitis + emphysema -</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr - Yrs -
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>Chronic bronchitis + emphysema -</u>									Yrs -
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from July, 1968, 19____, to April, 19 69, that (I) (we) last saw the deceased alive on 4-13-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. Lee Robbins				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/16/69.	
22d. PHYSICIAN'S NAME (Type) E. Lee Robbins				22e. ADDRESS 812 Mockingbird Lane					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/19/69.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS		25a. REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE John J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

<div>05046</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>05038</div>												
1. DECEASED-NAME (Type or print)			First William		Middle L.		Last Gover		2a. DATE OF DEATH Month Day Year April 10, 1969		2b. HOUR 10:50 P M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH April 3, 1912			6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS M N	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Industrial Labor			12b. KIND OF BUSINESS OR INDUSTRY Balto. Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Lutherville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 516 W. Seminary Ave. 21093	
14. FATHER'S NAME First Middle Last Walter Gover			15. MOTHER'S MAIDEN NAME First Middle Last Virgie Virginia Gover									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 220-03-3114			17. INFORMANT Address Mildred A. Gover, Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Massive Gastrointestinal Bleeding</u> 159X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>April 8</u> , 19 <u>69</u> , to <u>April 10</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 10</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Hector L. Feliciano M.D.</u>			22c. M.D. DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22d. DATE SIGNED 4-10-69			
22d. PHYSICIAN'S NAME (Type) HECTOR L. FELICIANO, M.D.			22e. ADDRESS 7620 York Rd., Towson, Md. 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE Apr. 14, 1969			23c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland			
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204			25a. REC'D BY REGISTRAR APR 11 1969			25b. REGISTRAR'S SIGNATURE <u>M. L. Dodge</u>						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

05047

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05039

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day 27 Year 1969		2b HOUR 7:30 A.M.	
LEON		GREENBERG									
3 SEX Male	4 RACE White	5 DATE OF BIRTH 9-21-1928	6 AGE (in years last birthday) 40 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD Month April Day 27 Year 1969		2d HOUR ? M	
7a BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				Md	
10 CITY OR TOWN OF DEATH RANDALLSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO. CO. GEN. HOSP.		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) PHARMACIST		12b KIND OF BUSINESS OR INDUSTRY DRUG STORE					
13a USUA. RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland		13b COUNTY Balto.		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2501 Hall Circle			
14 FATHER'S NAME ISADORE		First Middle Last GREENBERG		15 MOTHER'S MAIDEN NAME SARAH		First Middle Last KAPLAN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MRS. ANITA GREENBERG		ADDRESS 2501 HAL CIRCLE		#21209	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries 8120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 7:38 P.M. 4-26- 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subj. driver in auto-auto head-on collision							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No Beltway & Liberty Rd.		City or Town Balto.		County M.D.		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED 4/27/69							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 4-28-69		23c NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d LOCATION (City or Town) (County) (State) REISTERSTOWN, MARYLAND					
24 FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25a REC'D BY REG STRAR APR 30 1969		25b REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05043											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR			
Brenda Marie GRIFFITHS						Month 4 Day 15 Year 69		12:00 noon			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR			
Female		White		Dec. 6, 1954		14 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			
Maryland		U.S.A.				Baltimore		Owings Mills			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		13a. CITY OR TOWN		13b. STREET AND NUMBER			
Rosewood State Hospital		none		none		Baltimore		4555 Shamrock Ave.,			
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. INSIDE CITY, IN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER		13e. CITY OR TOWN			
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4555 Shamrock Ave.,		Baltimore			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
First Middle Last			First Middle Last			Yes, no, or unknown (If yes give war or dates of service)			-----		
Stephen - GRIFFITHS			Audrey Helen McGEE			no			-----		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19. DATE OF OPERATION			20a. AUTOPSY?		
Rosewood Records, Owings Mills, Md. 21117			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
			(b) Spasticity - brain damage								
			(c)								
			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			21d. INJURY OCCURRED		
<input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19						While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION			City or Town			County		
			Street or R.F.D. No								
22a. I certify that (I) (this hospital) attended the deceased from 11/16, 19 55, to 4/15/69, 19, that (I) (we) last saw the deceased alive on 4/15/ 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		
			Esteban V. Diaz M.D.			4/15/69			Esteban Diaz, M.D.		
23a. BURLAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			4/17/69			Holy REDEEMER Cem.			Baltimore, Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. ADDRESS		
LEONARD J. RUCK, Inc. Balto. 14, Md.			DATE APR 17 1969			Charles J. J. J.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) Harry S Grimes						2a. DATE OF DEATH Month 4 Day 11 Year 1969			2b. HOUR 2:55 AM			
3. SEX male		4. RACE White		5. DATE OF BIRTH 2-1-17			6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS 8 DAYS 2		IF UNDER 24 HRS. HOURS 2 MIN 55	
7a. BIRTHPLACE (State or foreign country) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. General Hospital			12a. USUAL OCCUPATION (Kind of work done during last year) Retired			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md.			13b. COUNTY Balto.		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 830 Milford miller			
14. FATHER'S NAME First George W. Middle Grimes Last Grimes				15. MOTHER'S MAIDEN NAME First Mabel R. Middle Johnson Last Johnson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 215-09-3555		17. INFORMANT Address Mabel R. Grimes - Same								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) 4123 Probably cardiac arrhythmias												
DUE TO, OR AS A CONSEQUENCE OF (b) intermediate heart disease												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE S. Chaiyavet				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-11-69						
22d. PHYSICIAN'S NAME (Type) J. Oster / Chaiyavet				22e. ADDRESS 714 N. Broadway St.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-14-69		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore Md.				
24. FUNERAL DIRECTOR Armacost Funeral Chapel - 4600 Liberty Highway				25a. FILED BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

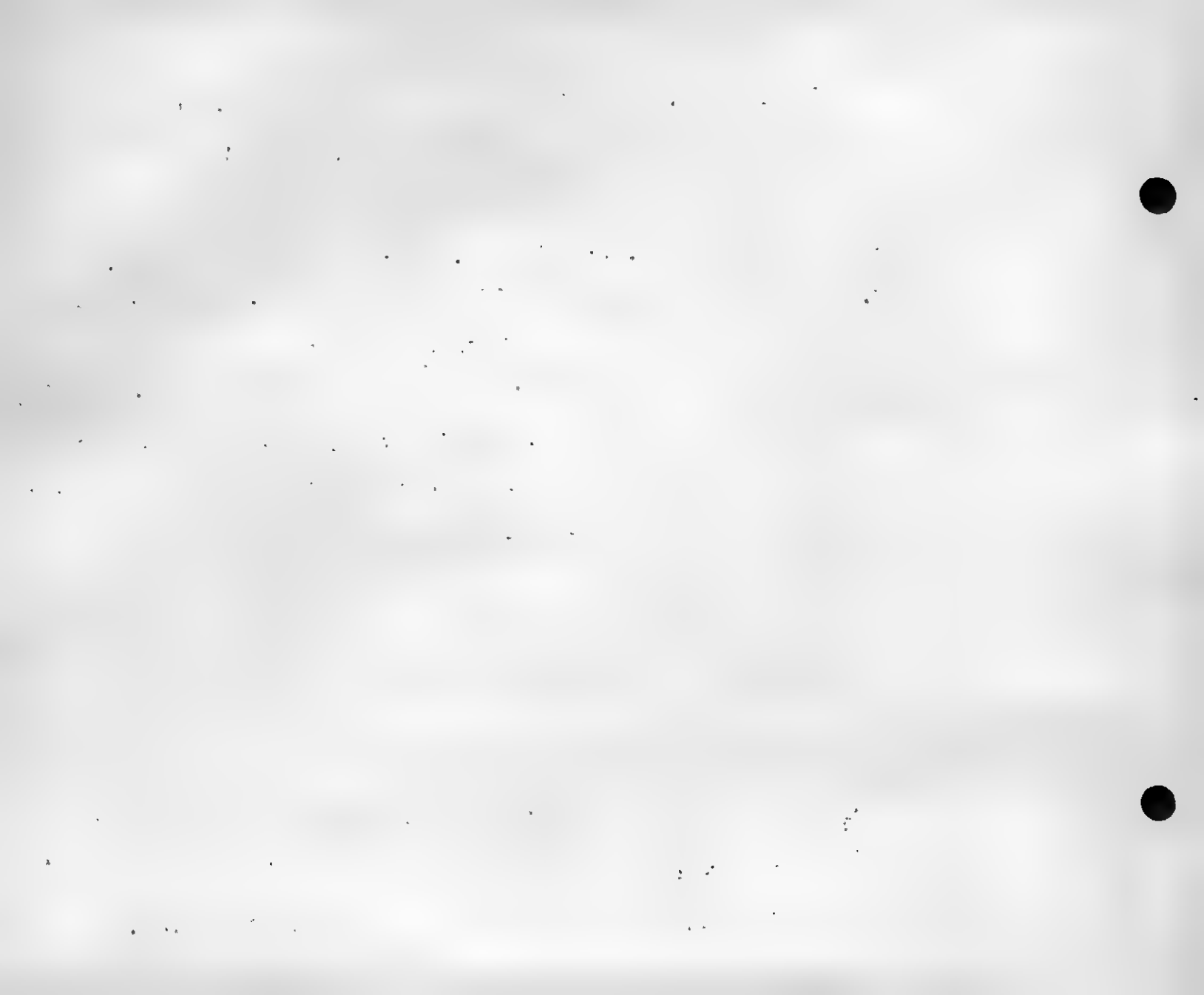
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

05050

05042

1. DECEASED-NAME (Type or print)		First IRENE	Middle R.	Last GROTZINGER	2a. DATE OF DEATH Month Day Year APRIL 13, 1969		2b. HOUR Minute 9:15 A		
3. SEX female		4. RACE white		5. DATE OF BIRTH September 22, 1894		6. AGE (in years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md.
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 400 S. Rolling Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 400 S. Rolling Rd.	
14. FATHER'S NAME First Middle Last John Bezold		15. MOTHER'S MAIDEN NAME First Middle Last Theresa Peters							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) none		17. INFORMANT Mr. William Grotzinger		Address 400 S. Rolling			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYPERTENSIVE AND ART. SCL. V. DIS. 10+ YRS DUE TO, OR AS A CONSEQUENCE OF (c) INFLUENZA SUSPECTED 1 WK APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH MINUTES									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 2, 1958 to APR 13, 1969 , that (I) (we) last saw the deceased alive on APR 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John N. Snyder M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/14/69	
22d. PHYSICIAN'S NAME (Type) JOHN N. SNYDER, M.D.		22e. ADDRESS 6348 FREDERICK RD CATONSVILLE MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 16, 1969		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md			
24. FUNERAL DIRECTOR Funeral Home		ADDRESS 736 Edmondson Ave.		25a. RECEIVED BY REGISTRAR APR 16 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



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05051

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05040

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
John		E.		Guetler	Month 4 Day 4 Year 69		12:15		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
Male	White		8/22/1895		73 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Randallstown		Balto. Co. Gen.		Sheet Metal Worker U.S. Govt.					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Balto.		Randallstown				10913 Steffeny Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
George Guetler					Julia Geidt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		WW I		220-44-8683		BCGH records, Randallstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension essential</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs many years many years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral thrombosis mild, not old</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSED DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 28, 1959</u> to <u>April 1969</u> , that (I) (we) last saw the deceased alive on <u>March 20, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>M. Davis, M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>MARVIN H. DAVIS</u>		22e. ADDRESS <u>6572 LIBERTY RD Balto 21207</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 8, 69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Baltimore County Md.</u>			
24. FUNERAL DIRECTOR <u>Loring Byers Chapel 8728 Liberty Rd. Randallstown</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>APR 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last WILLIAM T HALE						2a. DATE OF DEATH 4 Month 27 th 69 Year			2b. HOUR 12:45 M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 1/28/1903			6. AGE (In years last birthday) 65/66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			Md.			
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREATER BALTO. MED. CENT.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3908 Ridgcroft Rd.			
14. FATHER'S NAME First Middle Last Horace Hale				15. MOTHER'S MAIDEN NAME First Middle Last Mary Haynie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO 212 07 8788A			17. INFORMANT Address Mrs. Vera G. Hale 3908 Ridgcroft Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) CA OF LARYNX												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <u>1/18</u> , 19 <u>69</u> , to <u>4/27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Bahram Esлами						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 4/27/69			
22d. PHYSICIAN'S NAME (Type) BAHRAM ESLAMI						22e. ADDRESS 6701 N. CHARLES ST.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-29-69		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park			23d. LOCATION (City or Town) (County) (State) Baltimore Co., Maryland				
24. FUNERAL DIRECTOR William E. Johnson 8521 Loch Raven Blvd. 21204						25a. REC'D BY REGISTRAR MAY 1 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05053										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05045			
CERTIFICATE OF DEATH																							
1 DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH				2b. HOUR											
GLENN		-		-		HALFORD		APRIL Month 12, Day 1969 Year				2:15 PM											
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS													
MALE		NEGRO		1/29/1900		69 YRS.		MONTHS		DAYS		HOURS		MIN									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH																	
SOUTH CAROLINA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY																	
FORT HOWARD		VETERANS ADMIN. HOSPITAL		MOTOR OPERATOR		Steel																	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER															
MARYLAND		BALTIMORE		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3016 BAKER STREET															
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last									
BEN		-		-		HALFORD		HAGGER		-		-		JOHNSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address																	
YES		WWI		218 05 2169		CLINICAL RECORDS, VAH, FT. HOWARD, MD.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PLEURAL EFFUSION AND PNEUMONIA																3 WEEKS							
151.9 DUE TO, OR AS A CONSEQUENCE OF GASTRIC CA																8 - 12 MONTHS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
DUE TO, OR AS A CONSEQUENCE OF																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (X) (this hospital) attended the deceased from DEC 28, 1968, to APR 12, 1969, that (X) (we) last saw the deceased alive on APR 12, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.																							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS																	
JAMES K. DAVIS, M.D.		4/12/69		JAMES K. DAVIS, M.D.		VAH, FT. HOWARD, MD.																	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)																	
BURIAL		4-17-69		BALTO. NATIONAL CEMETERY		BALTIMORE, MD.																	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
NUTTER FUNERAL HOME		3035 W. NORTH AVE., BALTO., MD.		DATE APR 16 1969		Charles Judge																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1 DECEASED NAME (Type or print) <i>ada</i> <i>S</i> <i>Hall</i>						2a. DATE OF DEATH 4 xx Month 7 Day 69 Year			2b. HOUR 5:30 M		
3 SEX <i>Female</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>3-28-88</i>		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.					
10. CITY OR TOWN OF DEATH <i>Baltimore 28</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Caton Rd. N.W.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>SALES</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>	
13a. U.S. RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>md.</i>				13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1015 Adcock Road</i>	
14 FATHER'S NAME <i>John School</i>				15 MOTHER'S MAIDEN NAME <i>Louise</i>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO <i>212-22-5808</i>				17 INFORMANT <i>J. Hansen Rn</i> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Influenza-like illness</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day 4 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Generalized arteriosclerosis - Severe Chronic Brain Syndrome</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>2-24-1967</i>, to <i>4-xx-7-1967</i>, that (I) (we) last saw the deceased alive on <i>4-xx-7-1967</i>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Cesar Valle Cervero M.D.</i>						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS		22c. DATE SIGNED <i>4-7-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>CESAR VALLE CAVERO M.D.</i>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4-9-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>mt Olivet</i>				23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE md</i>			
24. FUNERAL DIRECTOR <i>Wm Cook-Beck-Toussan</i>						ADDRESS <i>1450 York Road</i>		25a. REC'D BY REGISTRAR <i>1655m Md 21204</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Under</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			2a. DATE OF DEATH			2b. HOUR			
First	Middle	Last	Month	Day	Year				
Dorothy Phillips Hall			April	28	1969	5:10 PM			
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female		White		6-23-1898		70 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
		U.S.A.				Baltimore Co. Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Lutherville		College Manor		School Teacher (Ret.)		School			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Harford		Bel Air				Medical Hall Farm	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First	Middle	Last	First	Middle	Last				
Sidney		Hall (D)	Anne	F.	Crampton (D)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
No					Anne I. Hall, Medical Hall Farm, Bel Air, Md				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>degenerative brain disease</u>									4 yrs.
4379 DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.V.A.</u>									3 years
DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral arterio sclerosis</u>									5 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 5, 1966</u> to <u>April 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Palmer P. Williams, M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED <u>April 28, 1969</u>				
22d. PHYSICIAN'S NAME (Type) <u>PALMER P. WILLIAMS</u>					22e. ADDRESS <u>Cowens Mills, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1 May 1969		Spesutia Cemetery		Perryman, Maryland			
24. FUNERAL DIRECTOR <u>Tarring Funeral Home</u> <u>Walter L. Coulter Jr.</u> <u>Aberdeen, Md. 21001</u>					25a. REC'D BY REGISTRAR <u>MAY 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. ~~Some~~ Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05056

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

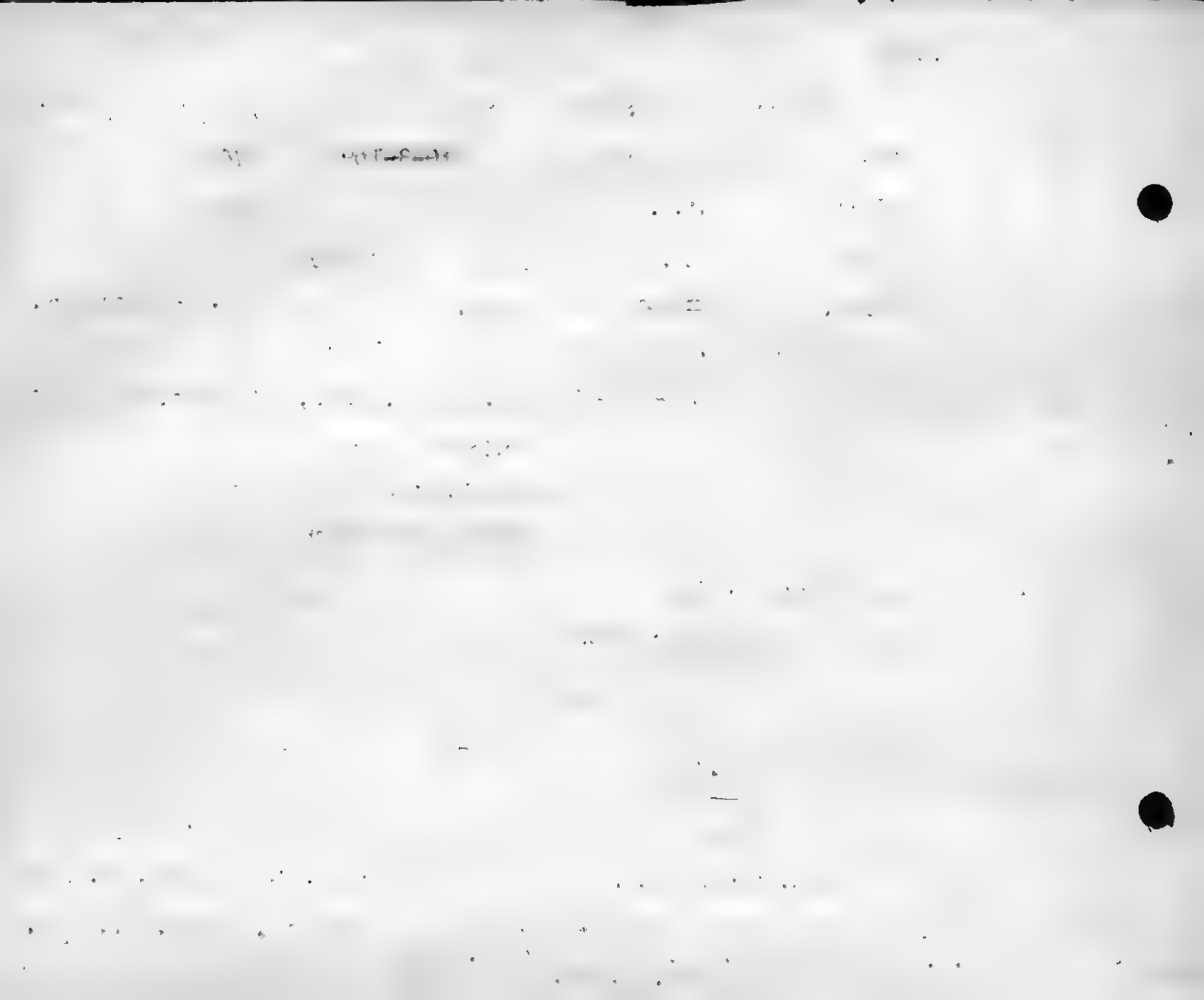
05048

1 DECEASED NAME (Type or Print) <u>Leslie Grant Harrison</u> Alva Clatus H				2a DATE KNOWN OF ESTI- DEATH MATED <u>April 10 1969</u>				2b HOUR <u>1 P M</u>	
3 SEX <u>Male</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>Dec 12, 1902</u>	6 AGE (In years last birthday) <u>66</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD <u>April 10 1969</u>		2d HOUR <u>1 P M</u>	
7a BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u>		Md	
10 CITY OR TOWN OF DEATH <u>Towson</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <u>Country Club of Maryland</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Groundskeeper</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Country Club</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <u>Baltimore Md.</u>		13b. COUNTY <u>Baltimore</u>		13c CITY OR TOWN <u>Towson</u>		13e STREET AND NUMBER <u>252 Ridge Avenue</u>			
14 FATHER'S NAME First Middle Last <u>William Harrison</u>				15. MOTHER'S MAIDEN NAME First Middle Last <u>Florence Wells</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO <u>None</u>		17 INFORMANT <u>Agnes S. Harrison, 252 Ridge Ave., Towson, Md.</u>					
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion Sudden</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Charles J. Connolly</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <u>410/69</u>				22b. DATE SIGNED <u>4/10/69</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b. DATE <u>April 14, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Parkville, Maryland</u>			
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>APR 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Connolly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
Eleanor		Bentley		Hart				Month	Day
								4	17
								Year	5:24 P M
								69	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR	
female		White		10-3-1894		74 YRS.		MONTHS	
								DAYS	
								HOURS	
								MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		St. Joseph Hospital		homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Baltimore		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		346 E. Belvedere Ave.	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Lawrence		E.		Parks				Mary	
								German	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		22-427-694		Mr. John B. Hart		37 Orthoridge Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Complete Heart Block</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
4-17-69		Complete Heart Block		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. ex. examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County	
While <input type="checkbox"/> Not while <input type="checkbox"/>				Street or R.F.D. No.				State	
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>4-15-69</u> , 19 <u> </u> , to <u>4-17-69</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4-17-69</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.	
<u>John J. Messina M.D.</u>				<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22c. DATE SIGNED					
John J. Messina, M.D.		7620 York Road, Baltimore, Md. 21204		4-17-69					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		4/21/69		Prospect Hill		Towson, Balto. Co., Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		APR 18 1969		<u>Charles Jones</u>					



CERTIFICATE OF DEATH

05050

1. NAME OF DECEASED
(Type or Print)

CECELIA HARTZ

2. DATE AND HOUR OF DEATH

APRIL 28, 1969 12:30 P, M

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

BALTIMORE COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

MILFORD MANOR NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

FLEETWOOD APTS.

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

78

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

LATVIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

BENJAMIN FOX

14. MOTHER'S MAIDEN NAME

SARAH

?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NO

17. INFORMANT

AMERICANA LANDMARK APTS.
MR. STANLEY HARTZ, APT. 16, 2907 FALLSTAFF RD. #9

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
4/23
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF

C. V. A

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF

A. S. H. D.

3 years

(C) DUE TO, OR AS A CONSEQUENCE OF

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL

22. I certify that (I) (this hospital) attended the deceased from 4/23 to 4/28 1969 that (I) (we) last saw the deceased alive on 4/28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Israel Zinberg

DEGREE

Attending Phys ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

4/28/69

23C. PHYSICIAN'S NAME (Type)

ISRAEL ZINBERG

23D. ADDRESS

DEGREE

4001 W. NORTHERN PKWY.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4-30-69

24C. NAME OF CEMETERY OR CREMATORY

MIKRO KODESH-BETH ISRAEL

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

VR AT 45M -

25A. DATE REC'D BY HEALTH DEPT

MAY 2 1969

25B. NAME OF REGISTRAR

John A. Jones

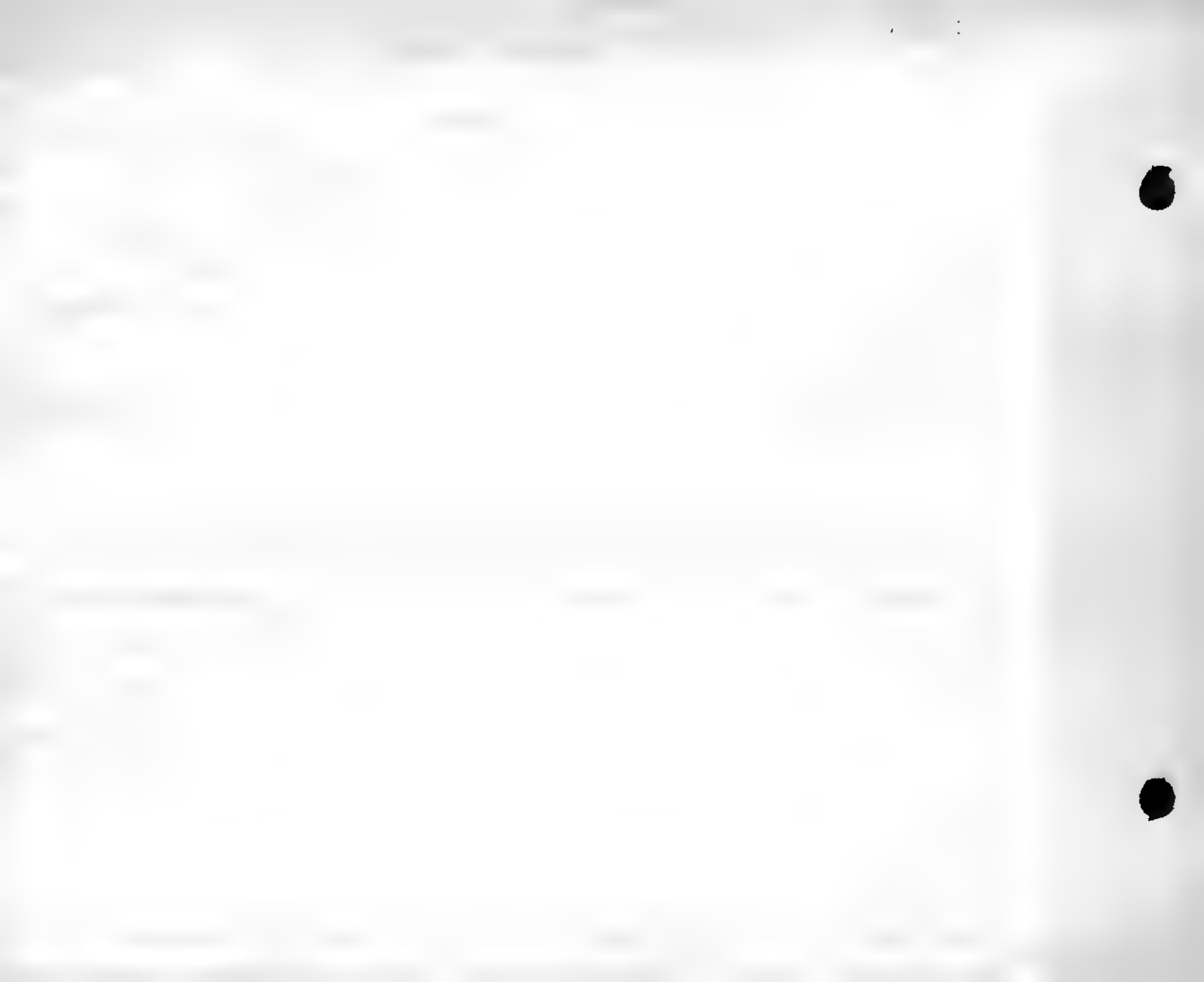
25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05059

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05051

1 DECEASED-NAME (Type or Print) <i>HUBERT ALLEN</i>		M date <i>First</i>		Last <i>HAWES</i>		2a DATE KNOWN OF DEATH ESTI <input checked="" type="checkbox"/> Month Day Year <i>APR. 4 1969</i>		2b HOJR <i>8:50 AM</i>	
3 SEX <i>Male</i>	4 RACE <i>W.</i>	5 DATE OF BIRTH <i>Aug 30, 1905</i>	6 AGE (In years last birthday) <i>63</i> YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year <i>Apr 4 1969</i>	2d HOJR <i>8:50 AM</i>
7a BIRTHPLACE (State or foreign country) <i>W. VA. USA</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i>			
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>8508 Fieldway Dr.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>accountant</i>		12b K MD OF BUSINESS OR INDUSTRY <i>640 R.R.</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Balt.</i>		13c CITY OR TOWN <i>Randallstown</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <i>8508 Fieldway Dr.</i>	
14 FATHER'S NAME <i>Jesse</i>		First Middle Last <i>Hawes</i>		15 MOTHER'S MAIDEN NAME <i>Mina</i>		First Middle Last <i>Vaughn</i>			
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16b SOCIAL SECURITY NO. <i>718-16-7119</i>		17 INFORMANT <i>Mrs Idris Carter Hawes</i>		ADDRESS <i>(same.)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary artery disease</i> <i>4-1</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3mt.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ulcerative colitis</i>									
19a. DATE OF OPERATION <i>1963</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ulcerative colitis</i>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <i>none</i>		21b TIME OF INJURY Month, Day, Year HOUR AM PM <i>none</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>none</i>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <i>none</i>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>none</i>		21f LOCATION Street or RFD No City or Town County State <i>none</i>					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>D. D. Caples</i>		EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>4/6/69</i>	
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b DATE <i>4-9-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Hunington W. Va Cem.</i>		23d LOCATION (City or Town) (County) (State) <i>Hunington W. VA.</i>			
24 FUNERAL DIRECTOR <i>Loring Byers Chapel</i>		ADDRESS <i>8728 Liberty Rd</i>		25a REC'D BY REGISTRAR <i>APR 9 1969</i>		25b REGISTRAR'S SIGNATURE <i>J. J. Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
ELEANOR OTTENHEIMER HESS						APRIL 18 1969		2 P. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		JULY 1, 1888		80 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
BALTIMORE, MD.		U.S.A.				BALTIMORE				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			DULANEY TOWSON NURSING HOME			HOUSEWIFE		AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			BALTIMORE		TOWSON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		204 Milford Mill	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
ELEAZIE O. OTTENHEIMER			AMELIA GREENBAUM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT Address				
NO						MR. EDWIN OTTENHEIMER, 303-1st NAT. BANK BLDG.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis CV + CNS disease</u>									6 ± yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
none						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
none										
22a. I certify that (I) (this hospital) attended the deceased from <u>2/22 1967</u> , to <u>4/18 1969</u> , that (I) (we) lost saw the deceased alive on <u>4/16 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Maurice Feldman</u> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/19/69</u>		
22d. PHYSICIAN'S NAME (Type) MAURICE FELDMAN						22e. ADDRESS <u>6610 CROSS COUNTRY BLVD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL			4-21-69		HEBREW FRIENDSHIP		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>						25a. REC'D BY REGISTRAR <u>APR 23 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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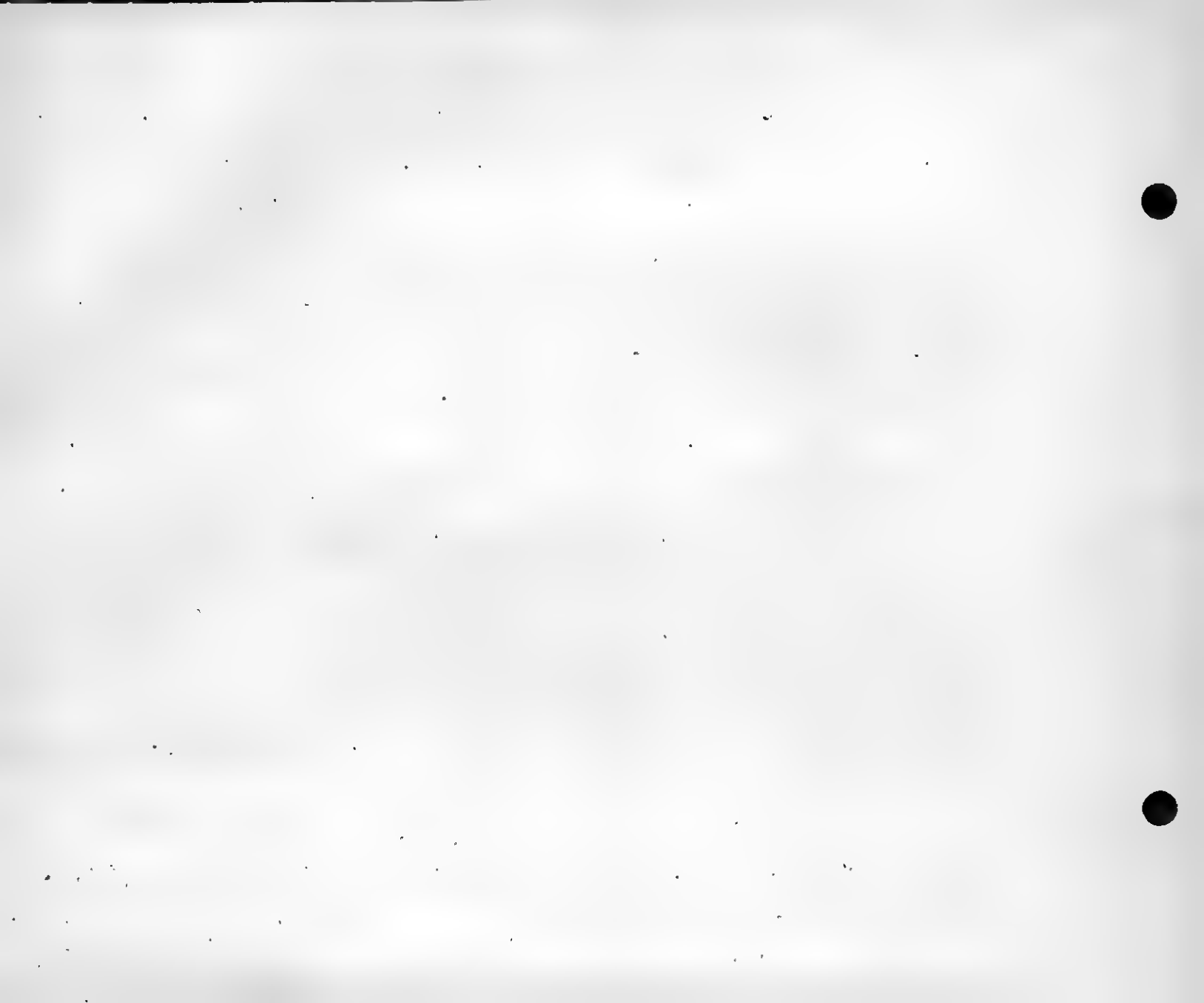
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR
Wilmer P.				Hesse				4 Month 17 Day 69 Year		5:50 AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Male		W		7/26/89		79 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED WIDOWED		NEVER MARRIED D. VORCED		9. COUNTY OF DEATH		Md
Md.		USA						Baltimore		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. U.S. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore 21228		Summit Nursing Home		Retired						
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS		13d. STREET AND NUMBER				
Md.		BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		118 Allendale St.				
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last
John				Hesse				Barbara V.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address				
No		216-10-4455		Mrs. Hilda Schaeffer		118 N. Allendale St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Pneumonia Terminal										7 days
4330 DUE TO, OR AS A CONSEQUENCE OF (b) Corbrot Muscles General Paralysis										3/1/69
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Corbrot Muscles Left Side Hemiplegia										1954
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Hyperuricemia Cardio Vascular Disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 1954, 19 to 4/17, 19 69, that (I) (we) last saw the deceased alive on 4/17, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
Eliot Johnson M.D.		4/17/69		Dr. E. W. Johnson		3437 Frederick Ave Baltimore Md 21229				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		4/19/69		Woodlawn Cemetery		Baltimore, Md.				
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
						DATE APR 17 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115 (4)
30M REV. 11-76B

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05062		CERTIFICATE OF DEATH						05054	
1. DECEASED-NAME (Type or print)			First <u>Maria</u> Middle <u></u> Last <u>Hiewsky</u>		2a. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1967</u>			2b. HOUR <u>5 A M</u>	
3. SEX <u>Female</u>		4. RACE <u>Cauc</u>		5. DATE OF BIRTH <u>17 Aug 1918</u>		6. AGE (In years last birthday) <u>50</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (State or foreign country) <u>Russia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md.			
10. CITY OR TOWN OF DEATH <u>Catonsville</u> <u>Baltimore, Maryland</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Shangra-la Nursing Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Health Aid</u>		12b. KIND OF BUSINESS OR IND. STRY. <u>City of Baltimore</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u></u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>2037 E Lombard Street</u>	
14. FATHER'S NAME First <u>Victor</u> Middle <u>-</u> Last <u>Garais</u>			15. MOTHER'S MAIDEN NAME First <u>Varvara</u> Middle <u>-</u> Last <u>Macht</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>097-28-1451</u>		17. INFORMANT Address <u>Wolodimir Hiewsky 4723 Newcouper Rd</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure - Hypotension</u> <u>1727</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Increased Intracranial Pressure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Glioblastoma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mths</u> <u>10 mths</u> <u>10 mths</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>NONE</u>									
19a. DATE OF OPERATION <u>June 1968</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Glioblastoma</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>21 Jan</u> , 19 <u>64</u> , to <u>3 April</u> , 19 <u>67</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>21 March</u> , 19 <u>67</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(1)</u> (we) <u>(did)</u> (did not) view the body after death.									
22b. SIGNATURE <u>Richard R. Stephenson M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>3 April 1967</u>			
22d. PHYSICIAN'S NAME (Type) <u>Richard R. Stephenson M.D.</u>				22e. ADDRESS <u>1302 Crofton Road, Balt. Md 21212</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4/7/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR ADDRESS <u>M. F. SADOWSKI & SONS, 1808 EASTERN AVE.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05063

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05055

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year			2b HOUR			
AMELIA			HILDEBRAND			Month Day Year			11:17			11:17			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			
Female		White		Oct 13		77 YRS		MONTHS DAYS		HOURS MIN		Month Day Year			
7a BIRTHPLACE (State or foreign country)		7b COUNTRY OF BIRTH		8 MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9 COUNTY OF DEATH			
Balto		US		X								Baltimore Md			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY			
Towson				Greater Balto. Medical Center											
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?			
Md.				Balto.				Balto.				YES NO			
14 FATHER'S NAME				15 MOTHER'S MARRIED NAME				16a WAS DECEASED EVER IN U.S. ARMED FORCES?				16b SOCIAL SECURITY NO			
Wm Roch				Rathemue											
17a INFORMANT				17b ADDRESS				17c STREET AND NUMBER				17d CITY AND STATE			
Melvin O Hildebrand				219 Forrest Rd				2922 E. Coldspring Lane							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Pulmonary embolus															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Adenocarcinoma of the uterus															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?							
								YES NO							
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
CAUSE OF DEATH				HOUR A.M. P.M.											
21d INJURY OCCURRED				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town		County	
WHILE AT WORK HOT WHILE AT WORK															
22a I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner															
22b DATE SIGNED				22c CHIEF MEDICAL EXAMINER				22d DATE SIGNED							
April 16, 1969				Assistant Medical Examiner											
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)							
Ronald N. Kornblum, M.D.															
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town)		(County) (State)	
Burial				4/19/69				Cathwood				Baltimore		Maryland	
24 FUNERAL DIRECTOR				25a REC'D BY REG STRAR				25b REGISTRAR'S SIGNATURE							
J. Heemann				APR 22 1969				Charles George							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05064

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05056

1 DECEASED NAME (Type or Print)		First ROSE	Middle	Last HODGES	2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year		2b HOUR
3 SEX female	4 RACE white	5 DATE OF BIRTH 4/30/92	6 AGE (in years last birthday) 76 YRS	7 UNDER YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c DATE PRONOUNCED DEAD Month 4/4/69 Day 2 Year 1969	2d HOUR 15 AM
7a BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore	
10. CITY OR TOWN OF DEATH Benjies		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 14, Box 13		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machine Opr. Continental Can		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME Charles J. Hart		15 MOTHER'S M.A.DEN NAME Kate White		17. INFORMANT Benjies, Md. ADDRESS 21220 Milred W. Harrod, dght. Rt. 14, Box 13			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO 215-03-3674		17. INFORMANT Benjies, Md. ADDRESS 21220 Milred W. Harrod, dght. Rt. 14, Box 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Dr. Theodore C. Patterson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 4/6/69	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4/7/69		23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane				25a RECD BY REGISTRAR APR 11 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

1601

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05065									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
CARVEL			HOLLAND			Month Day Year APRIL 27, 1969			8:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		NEGROID		9/24/27		41 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hosp. give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		HOSPITAL VETERANS ADMINISTRATION		TRUCK DRIVER					
13a. US. AL RESIDENCE (Where deceased lived, first in nation Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND				BALTIMORE				640 MELVIN DRIVE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
LOUIS			HOLLAND			LOUISE CARROLL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
YES			WWII			218 19 8351 CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA LEFT LUNG</u>									UNKNOWN
1621 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/2/69, 19__, to 4/27/69, 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/27/69, 19__, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
JOHN D. TALBERT, M. D.					4/28/69				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					VA HOSPITAL, FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5-2-69		Balto. National Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Rice Funeral Home		661 W. Berre Street Baltimore, Maryland		MAY 2 1969		John D. Talbert, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>Lila</i>			First <i>R</i>			Middle <i>Hollins</i>			Last		
2a. DATE OF DEATH			Month <i>April</i>			Day <i>23</i>			Year <i>1969</i>		
2b. HOUR			M <i>4:30</i>								
3. SEX <i>Female</i>			4. RACE <i>white</i>			5. DATE OF BIRTH <i>Aug. 18, 1896</i>			6. AGE (In years last birthday) <i>72</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Russell Co. Va.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i> Md		
10. CITY OR TOWN OF DEATH <i>Hampstead</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>RFD 2</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Baltimore</i>			13c. CITY OR TOWN <i>Hampstead</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <i>RFD 2</i>			14. FATHER'S NAME First <i>Samuel</i> Middle <i>Reed</i>			15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>Duncon</i> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>511-18-1666</i>			17. INFORMANT <i>Mrs. Charles H. Hargrader</i>			Address <i>Hampstead 2 - Md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>11124</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i> <i>7 years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>May, 1957</i> to <i>April 23, 1969</i> , that (I) (we) last saw the deceased alive on <i>April 22, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>W. H. Foard</i>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>4/24/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>W. H. Foard M.D.</i>			22e. ADDRESS <i>Manchester, Md 21102</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>April 26, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i>			23d. LOCATED ON (City or Town) (County) (State) <i>Finksburg, Carroll Md.</i>		
24. FUNERAL DIRECTOR <i>Tipton - Eline Funeral Home Hampstead, Md.</i>						25a. REC'D BY REGISTRAR <i>APR 29 1969</i>			25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
ETHEL BEAUCHAMP HOLLOWAY						4 29 Day 69 Year		9:20 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
FEMALE		CAUCASIAN		2-19-85		84 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		U.S.A.				BALTIMORE Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		GREAT BALT MED CENTR.		Housewife		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Harford		Perryman,				N/A	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Willard Henry Hinchman (D)			Ella Stockham (D)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
		220-34-6300		Gertrude Spang,		Aberdeen, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>METASTATIC CA WITH HEART FAILURE</u>								LONG STANDING	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-25, 19 69, to 4-29, 19 69, that (I) (we) last saw the deceased alive on 4-29, 19 69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
Neeraja Thakur									4/29/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
DR. NEERAJA THAKUR					Baltimore, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2 May 1969		Spesutia Cemetery		Perryman, (Harford Co.) Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tarring Funeral Home					MAY 2 1969		[Signature]		
Aberdeen, Md. 21001									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05068									
05060									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
GUSTAF			W. HOLMGREN			April 30 1969		5 ¹⁰ PM	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		Dec. 30, 1916		32 YRS		MONTHS DAYS HOURS M.N.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Conn.		USA				BALTIMORE Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp ital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson		Greater Balto. Med. Cen.		Salesman					
13a USUAL RESIDENCE (Where deceased admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		Balto.		Towson				8207 Lockraven Blvd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Rudolph Holmgren			Dorothy Tanner						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give branch or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address			
Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>		043-07-1342		Mrs. Lois Holmgren		Towson, Md. 21204			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>DIABETIC GLOMERULOSCLEROSIS</u>								2 YEARS	
DUE TO OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b) <u>DIABETES MELLITUS</u>								2 1/2 YEARS	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NONE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No		City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <u>MARCH 1969</u> to <u>APRIL 30, 1969</u> , that (I) (we) last saw the deceased alive on <u>APRIL 7, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED			
<u>Howard H. Gendason MD.</u>				DEGREE		<u>APRIL 30, 1969</u>			
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS					
<u>HOWARD H. GENDASON MD.</u>				<u>REISTERS TOWN, MD.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
<u>Burial</u>		<u>May 5, 69</u>		<u>Baltimore National</u>		<u>Baltimore, Md.</u>			
24 FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>J. F. Eline & Sons</u>				<u>Reisters town, Md.</u>		<u>MAY 5 1969</u>		<u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First William			Middle Hoyt		Last (Hoyte)		2a. DATE OF DEATH Month Day Year April 13, 1969		2b. HOUR 10:00 a. M.	
3 SEX male		4 RACE white		5. DATE OF BIRTH 10/12/1879		6 AGE (in years last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.							
10 CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Packaging Ind.				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY BALTO.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Baltimore City Hospitals				
14 FATHER'S NAME First Middle Last JOHN HOYT			15 MOTHER'S MAIDEN NAME First Middle Last ELIZABETH BRADEN										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service) 219-54-3165J1		17 INFORMANT Address Records : SPRING GROVE STATE HOSPITAL								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY) (OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>May 11</u> , 19 <u>13</u> , to <u>April 13</u> , 1969, that (I) (we) last saw the deceased alive on <u>April 13</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b SIGNATURE <i>[Signature]</i>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 4-14-69							
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.				22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4-16-69		23c NAME OF CEMETERY OR CREMATORY Schwartz Cem				23d LOCATION (City or Town) (County) (State) Balto., Md.					
24 FUNERAL DIRECTOR John A. Miller Funeral Home				25a REC'D BY REGISTRAR DATE APR 15 1969		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>							

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05070

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0506

1 DECEASED-NAME (Type or Print)		First Wilbert		Middle A.		Last Huffman		2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> APR 17 1969			2b. HOUR 11 A M	
3 SEX Male	4. RACE White	5. DATE OF BIRTH 11/10/11	6 AGE (in years past birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> April 17 1969			2d. HOUR 11 45 A M	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore						
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 1 Midway				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired-Bethlehem Steel Co.			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN 1 Midway		13d. INSIDE CITY L.M. 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1 Midway				
14. FATHER'S NAME First Walter Middle A. Last Huffman		15. MOTHER'S MAIDEN NAME First Lula Middle Belle Last Phillips										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 218-01-2526		17 INFORMANT (Wife) ADDRESS Mrs. Mable Huffman, 1 Midway, Dundalk, Md.								
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-Disease 4104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Melvin B. Davis		EXAMINER'S NAME (Type) Melvin B. Davis		M.D. M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/21/69		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		23d. LOCATION (City or Town) (County) (State) Dorsey, Maryland		22b. DATE SIGNED 4/18/69		22c. ADDRESS (Street, city, town, or county) 6800 Mornington Road Dundalk, Md. 21222		
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a. REC'D BY REG. STRAR DATE APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles Jones				



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05071

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05063

1. DECEASED-NAME (Type or Print) Wm. LESTER			First Middle Last HUGHES			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year April 1, 1969			2b. HOUR 5:50p		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10/22/08		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year April 1 1969	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.					
10. CITY OR TOWN OF DEATH Dundalk				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) In Auto outside 1200 Burkwood Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE MD.				13b. COUNTY Balto.		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 489 Hollytree Rd.	
14. FATHER'S NAME First Middle Last LAWRENCE HUGHES						15. MOTHER'S MAIDEN NAME First Middle Last ANNA TUEFEL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16b. SOCIAL SECURITY NO 220-14-1519		17. INFORMANT FAYE HUGHES				ADDRESS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 4124 Arteriosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward F. Wilson						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED 4/2/69					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 4/4/69		23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT.				23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS						ADDRESS 300 MACG					
25a. REC'D BY REGISTRAR APR 7 1969						25b. REGISTERED SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

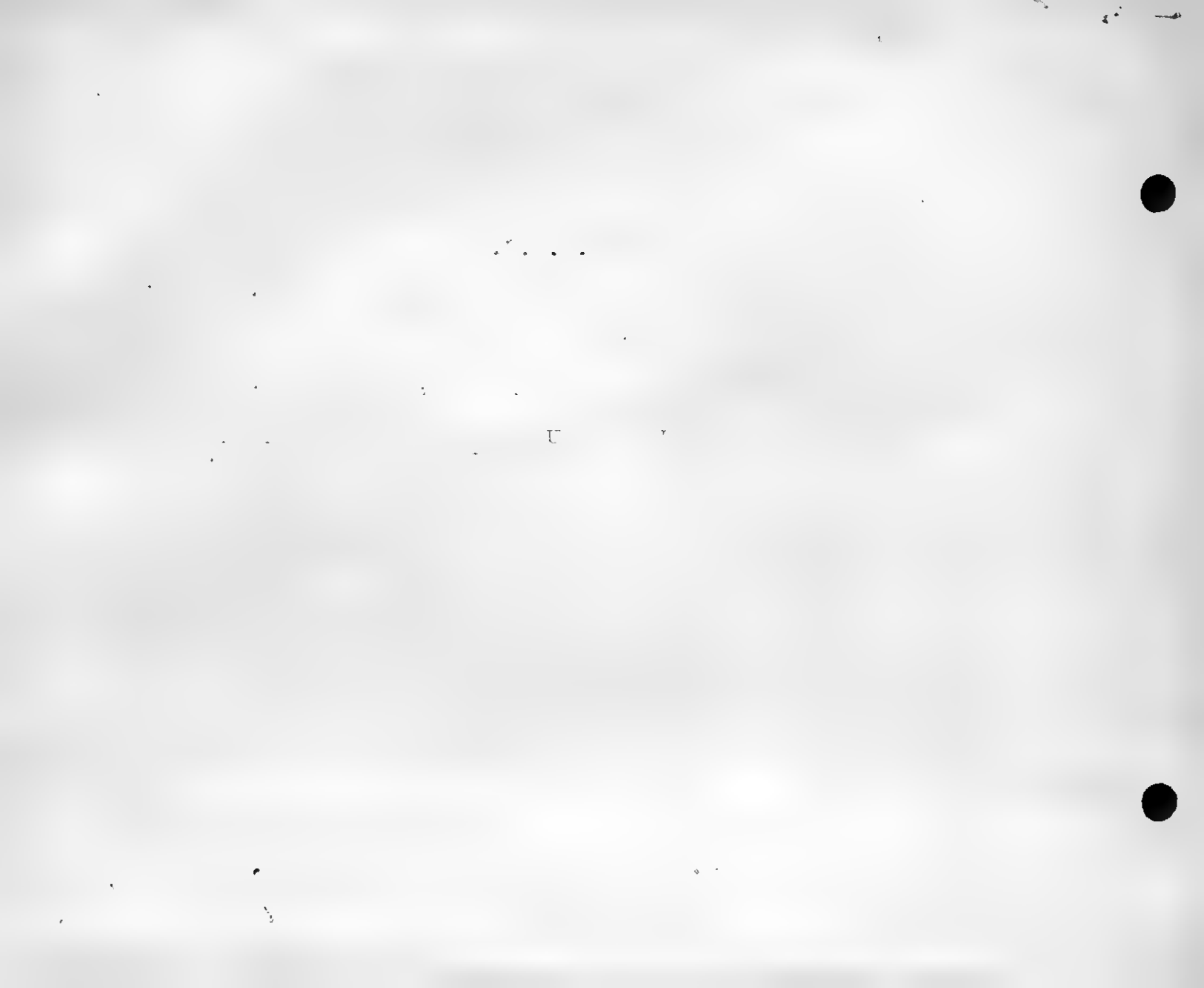
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) THOMAS			First H.		Middle HUNT		Last		2a. DATE OF DEATH 4 Month 14 Day 1969	2b. HOUR M	
3. SEX M		4. RACE W		5. DATE OF BIRTH AUG 15, 1895			6. AGE (In years lost birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BAITIMORE					
10. CITY OR TOWN OF DEATH CATONSVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 129 OAKDALE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CLERK			12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INS-DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 129 OAKDALE		
14. FATHER'S NAME THOMAS			First H.		Middle HUNT		Last		15. MOTHER'S MAIDEN NAME HAINES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES WW II			16b. SOCIAL SECURITY NO 212-07-2318		17. INFORMANT EMMA S. HUNT			Address 129 OAKDALE BALTIMORE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction											
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4-18-69 , to 4-18-69 , that (I) (we) last saw the deceased alive on 4-18-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Respectfully signed D. H. Haines, Jr. M.D.											
22b. SIGNATURE D. H. Haines, Jr.					DEGREE ATTENDING PHYS		2 MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-18-69		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/18/1969		23c. NAME OF CEMETERY OR CREMATORY ST. John			23d. LOCATION (City or Town) (County) (State) ELlicott City BALT. MD				
24. FUNERAL DIRECTOR E.S. McEuback					ADDRESS 301 Frederick Rd. 21228			25a. RECEIVED BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
05073											
05065											
1. DECEASED-NAME (Type or print) HUNTER VIRGINIA					2a. DATE OF DEATH Month 4 Day 4 Year 69					2b. HOUR 1:45 P. M.	
3. SEX FEMALE		4. RACE NEGRO		5. DATE OF BIRTH 10/18/24		6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS 4 DAYS 4		IF UNDER 24 HRS HOURS 1 MIN. 45	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) G.B.M.C.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE 1st COUNTY 1st			13c. CITY OR TOWN Baltimore		13d. INSIDE CITY - APTS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 518 N. Price Street				
14. FATHER'S NAME First Charles Middle Hunter Last Virginia					15. MOTHER'S MAIDEN NAME First Johnson Middle Johnson Last Johnson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO 215-24-1029		17. INFORMANT Address Mr. Charles Hunter 2552 Hollins Ferry Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RUPTURED ANEURYSM OF CIRCLE OF WILLIS 43-17 DUE TO, OR AS A CONSEQUENCE OF WITH SUBARACHNOID HEMMORHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4-3- , 19 69 , to 4-4- , 19 69 , that (I) (we) last saw the deceased alive on 4-4- , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles C. Brown, M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/4/69				
22d. PHYSICIAN'S NAME (Type) CHARLES C. BROWN					22e. ADDRESS 6701 N CHARLES ST. BALT, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Apr 8, 1969		23c. NAME OF CEMETERY OR CREMATORY McLukum Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore		23e. REGISTERED SIGNATURE Joseph H. Run			
24. FUNERAL DIRECTOR Joseph H. Run 2222 W. North Ave					25a. REC'D BY REGISTRAR DATE APR 11 1969		25b. REGISTRAR'S SIGNATURE Joseph H. Run				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
Charles			Edward		Husen, Jr.		April		Month Day Year 22 1969	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)	
Male			Negro			6-15-43			25 YRS.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
Maryland			USA						Baltimore Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Towson			St. Joseph			AIRCRAFT ARMAMENT			AIRCRAFT	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY - WITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland						Baltimore			4421 St. George Ave. #12	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Charles E. Husen, Sr.										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
Yes			VIETNAM			213-401029			Charlotte Ringgold 411 SWARTZ AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral and pontine hemorrhage										
4511 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from April 21, 1969, to April 22, 1969, that (I) (we) last saw the deceased alive on April 22, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
Reynaldo Orjuela-Gomez, M.D.			April 22, 1969			7620 York Road, Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			4-25-69			BALTO. NAT.			BALTO. Md.	
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Morton & Dyett Funeral Home, 1701 Laurens St. Balto. Md.			APR 23 1969			Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) Viola OLIE				Middle M.		Last IRVIN		2a. DATE OF DEATH 4 Month 16 Day 69 ^{ear}			2b. HOUR 4 ^{PM}	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-17-95			6. AGE (In years lost birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto			Md			
10. CITY OR TOWN OF DEATH Roadkilltown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Luke's Co. Gen.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) At Home			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY N		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3402 Woodbine Ave				
14. FATHER'S NAME First Howard Middle Shingler Last Shingler				15. MOTHER'S MAIDEN NAME First Vanallman Middle Vanallman Last Vanallman								
16a. HAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b. SOCIAL SECURITY NO -		17. INFORMANT Chart-Jacqueline Sullivan			Address 3402 W			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)												
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary edema												
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease												
DUE TO, OR AS A CONSEQUENCE OF (c) Infarction of Myocardium -												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
MEDICAL CERTIFICATION												
9a. DATE OF OPERATION 4-9-69		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Breast				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE R. Perez-Mera				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) R. Perez-Mera				22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-18-69		23c. NAME OF CEMETERY OR CREMATORY Moorestville Cemetery			23d. LOCATION (City or Town) (County) (State) - Neffs Mills PA					
24. FUNERAL DIRECTOR Armocost Funeral Chapel - 4600 Liberty Hwy				ADDRESS		25a. -REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

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05076

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05068

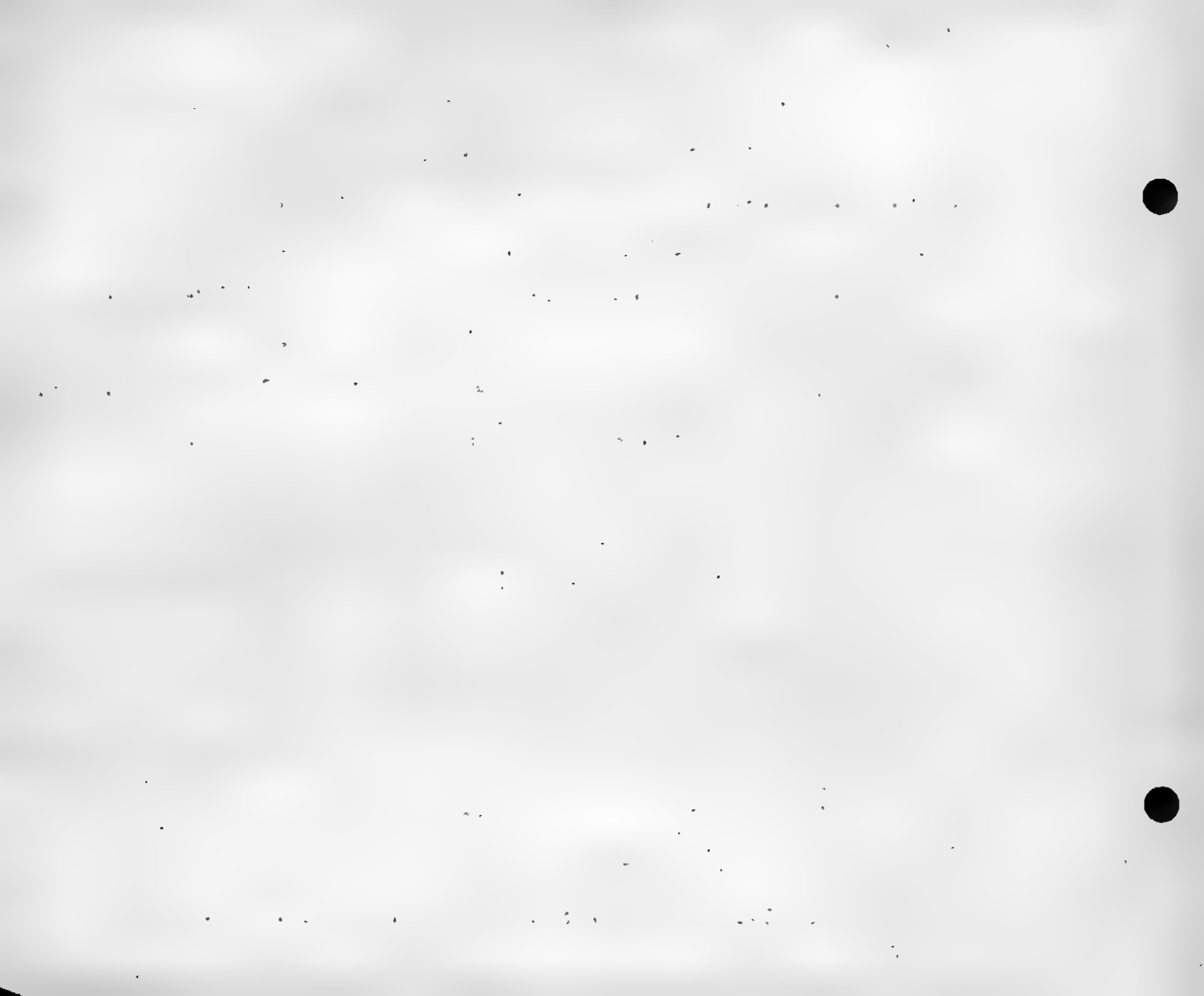
1. DECEASED-NAME (Type or print) First Middle Last WILLIAM HENRY JACKSON			2a. DATE OF DEATH Month Day Year APRIL 18, 1969			2b. HOUR 5:30 AM					
3 SEX MALE		4 RACE NEGRO		5 DATE OF BIRTH 8/27/18		6 AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.					
10. CITY OR TOWN OF DEATH FORT HOWARD			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMIN. HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired) KILN LOADER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2749 ROUND ROAD		
14. FATHER'S NAME First Middle Last ALFRED - - JACKSON			15. MOTHER'S MAIDEN NAME First Middle Last SARAH - - RANSOME								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) YES WWII			16b. SOCIAL SECURITY NO. 212 14 0814		17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR FAILURE, LEFT DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO CHRONIC NEPHRITIS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
									HOURS		
									YEARS		
									YEARS		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from APR 8 , 19 69 , to APR 18 , 19 69 , that (X) (we) last saw the deceased alive on APR 18 , 19 69 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <i>Alfonso A. Lopez</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4 19 69			
22d. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.						22e. ADDRESS VAH, FT. HOWARD, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/22/69		23c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.				
24. FUNERAL DIRECTOR MORTON & DYFIT FUN. DIR. BALTO., MD.						25a. RECD BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Edith Mae Jasper						April Month 29, 1969 Year		1220 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
Female		Colored m		Nov. 30, 1898		70 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Balto. Md.		U.S.A.				Balto. Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Halethorpe			4511 Spring Ave.			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Balto.		Halethorpe		YES <input type="checkbox"/> NO <input type="checkbox"/>		4511 Spring Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Lorenzo Barron			Catherine Madden							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No					Katherine Littles 1730 Moreland Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE + ATHEROSCLEROTIC CUM</u> <u>LIPOA</u> DUE TO, OR AS A CONSEQUENCE OF DISEASE & CHRONIC (b) <u>CONGESTIVE FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRAL ATHEROSCLEROSIS. SENILE DEMENTIA.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
CEREBRAL ATHEROSCLEROSIS. SENILE DEMENTIA.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED								
John F. Schaefer M.D.		5-1-69		DEPUTY MEDICAL EXAMINER ATTENDING <input type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> DEGREE PHYS <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
JOHN F. SCHAEFER		401 RANDOM ROAD - 21229								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		May 2, 1969		Balto. National Cem.		Balto. Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
William S. Schaefer		MAY 5 1969		William S. Schaefer						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05078

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05070

Items 14 & 15 Film 412 5/5/69 kk

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Katherine Marie Jasper</i>			2a. DATE OF DEATH <i>April</i> Month <i>24</i> Day <i>1969</i> Year			2b. HOUR <i>5:30</i> A.M.	
3. SEX <i>Female</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>Oct. 28, 1900</i>		6. AGE (in years last birthday) <i>68</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Carney</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>9620 Oak Summit Rd. 34</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Carney</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>9620 Oak Summit Rd. 21234</i>							
14. FATHER'S NAME First Middle Last <i>Herman Frederick R Schwartz</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Caroline Margaret S. Dietz</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>			16b. SOCIAL SECURITY NO. <i>212-52-6580</i>		17. INFORMANT <i>Edwin F. Jasper</i>		
			Address <i>9620 Oak Summit Road 21234</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cancer uterus</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Arterio sclerotic CVD Perkinson's</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> or work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> to <i>April 1969</i> , that (I) (we) lost the deceased alive on <i>April 22, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William A. Tyson M.D.</i>				22c. DATE SIGNED <i>4-24-69</i>		22d. PHYSICIAN'S NAME (Type) <i>William A. Tyson</i>	
22e. ADDRESS <i>Kingsville, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>Apr 28-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Michael's Lutheran</i>		23d. LOCATION (City or Town) (County) (State) <i>Perry Hall Balto. Md.</i>	
24. FUNERAL DIRECTOR <i>Lassahn Funeral Home</i>				25a. REC'D BY REGISTRAR DATE <i>APR 28 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

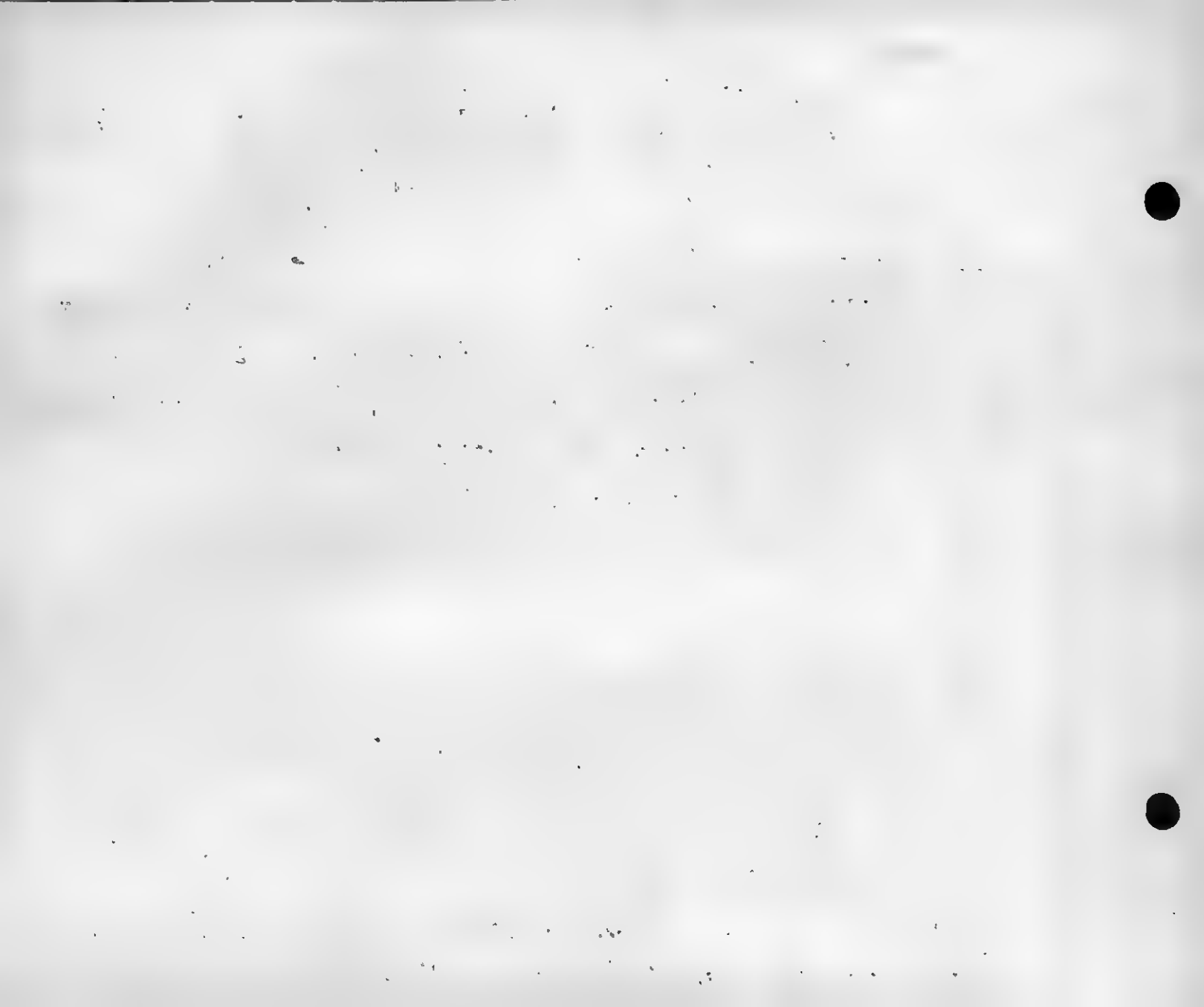
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05079

CERTIFICATE OF DEATH

05071

1 DECEASED NAME (Type or print) <u>Sr. Mary Agnes Jindra</u>		First <u>(Stona)</u> Middle Last		2a. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>69</u>			2b. HOUR <u>4:15</u> AM		
3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>1-18-1899</u>		6 AGE (In years last birthday) <u>70</u> YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md.			
10 CITY OR TOWN OF DEATH <u>Glen Arm</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Glen Arm Road</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Teacher</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Glen Arm, Md.</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <u>Mathias Jindra</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Petronila Boreas</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>		16b. SOCIAL SECURITY NO. <u>330-54-5098-T</u>		17. INFORMANT <u>Sr. M. Kathleen</u>		Address <u>same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Bleeding 20 To 25</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple myeloma.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>205X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>December, 1966</u> , to <u>April 3, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 3rd 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Henry L M CORKIE MD</u>		DEGREE <u>MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-5-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Henry L M CORKIE MD</u>		22e. ADDRESS <u>Phoenix, Md 21131</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4-7-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SISTER'S CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>GLEN ARM BALT. MARYLAND</u>			
24. FUNERAL DIRECTOR <u>RAYMOND J. CURRAN</u>		ADDRESS <u>817 S. E. 1ST ST. DR. LINDSEY, MD. 21054</u>		25a. REC'D BY REGISTRAR <u>APR 14 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05080

CERTIFICATE OF DEATH

05072

1 DECEASED-NAME (Type or print) ETHEL BEASTON JOHNSON			2a. DATE OF DEATH April Month 6 Day 1969 Year			2b. HOUR M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 9-29-1887		6. AGE (In years lost birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney-Towson Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Dumbarton Road	
14. FATHER'S NAME First Middle Last Theodore Lewis			15. MOTHER'S MAIDEN NAME First Middle Last Sara						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 214-46-8556		17. INFORMANT Address Shirley J. Hannon, 107 Aylesbury St. 21093				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arterio sclerotic Cardio Vascular Disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDINGS, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 4th</u> , 19 <u>68</u> , to <u>April 6th</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 5th</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>M. K. Quinn MD</u> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>4/8/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>M. K. QUINN MD</u>				22e. ADDRESS <u>1927 York Rd TIMONKON MD</u>					
23a. BURIAL CREMATION, Burial (Specify)		23b. DATE <u>4-9-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Maryland</u>			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204				25a. REC'D BY REGISTRAR <u>APR 9 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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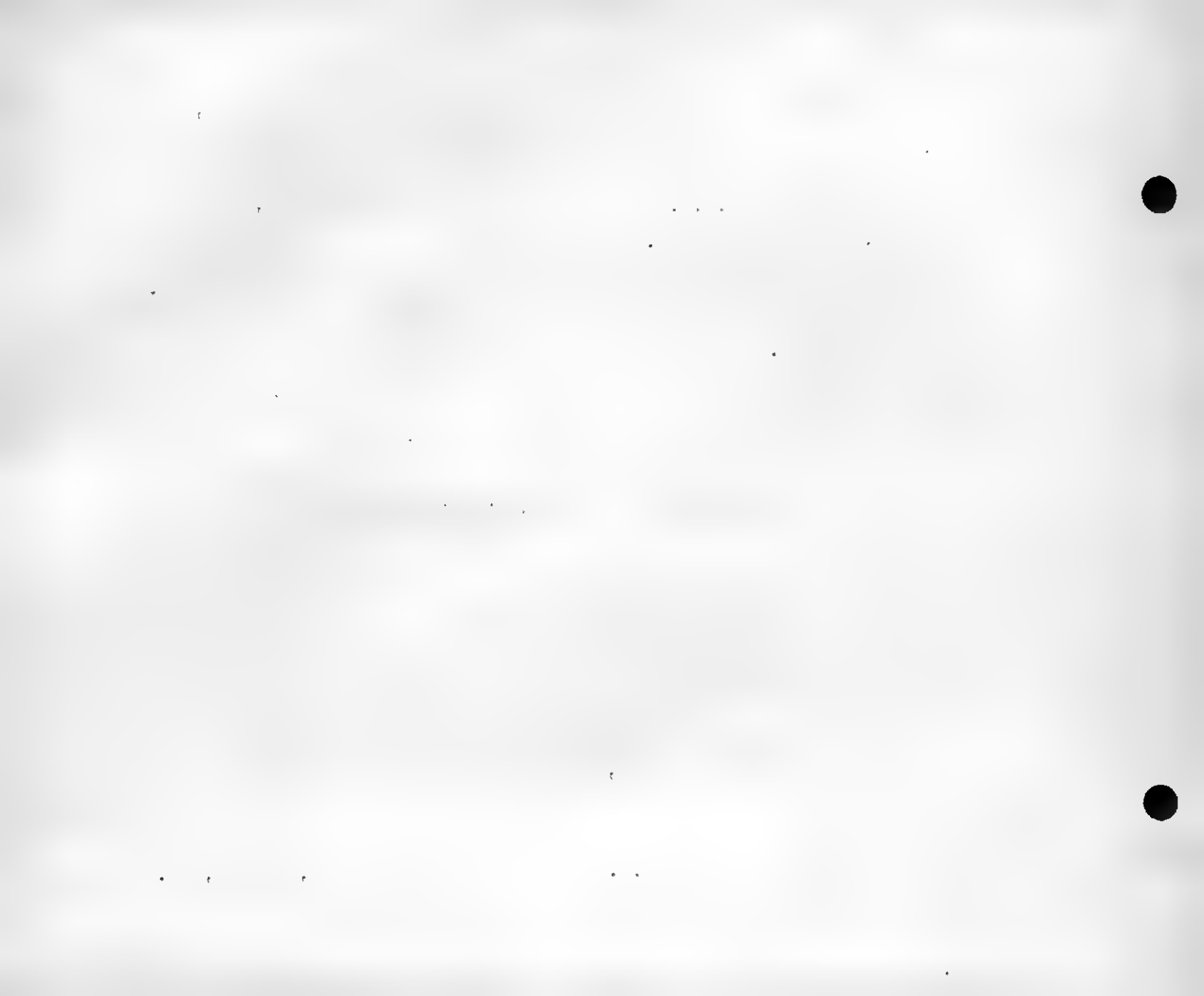
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30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Geneva			Pearl	Johnson	Month 4 Day 18 Year 1969			10:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR			
Female		Negro		1898		71 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore Md.		USA				Baltimore Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore 21228			Eaton Ridge Nursing Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.					Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		725 George St. 21217		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JOHN ELLIOTT						Elizabeth Paige					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
NO			215-05-9285-A			Eaton Ridge Nursing Home			329 Harlem Lane		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Brouchopneumonia</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Aspiration</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Generalized Arteriosclerosis - Chronic Brain Syndrome</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>Cesar Valle Cervero</u>								4-21-69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
CESAR VALLE CAVERO				86 29 Liberty Rd							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		4-21-69		Mt. Auburn Cemetery		Baltimore, Maryland					
24. FUNERAL DIRECTOR				ADDRESS		25a. DATED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DYOTT FUNERAL HOMES, INC.				1701-31 Laurens St., Balto., Md. 21211		APR 21 1969		<u>John A. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HO. JR.
HELEN D. JOHNSON						APRIL Month 29, Day 1969 Year			11:00P
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
FEMALE		WHITE		NOVEMBER 25, 1895		73 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. K NO OF BUSINESS OR INDUSTRY	
ILLINOIS		U.S.A.				BALTIMORE,		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INST TUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. K NO OF BUSINESS OR INDUSTRY			
TOWSON		JOSEPH HOSPITAL		HOMEMAKER					
13a. USUAL RESIDENCE (Where deceased admission)		13b. CITY OR TOWN		13c. STREET AND NUMBER		13d. RESID. CITY L.M. TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7500 HARFORD RD. #21234			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
CHARLES F. DEWEND						ANNA KUSCHMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			220-1402488			Hospital records			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage									
DUE TO, OR AS A CONSEQUENCE OF Berry aneurysm of the right posterior communicating artery									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from April 29, 1969, to April 29, 1969, that (X) (we) lost saw the deceased alive on April 29, 1969 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
Lawrence Misanik, M.D.						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		4-30-69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
						7620 York Road, Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		5/2/69		Parkwood cemetery		Balto Co. Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
C.F. EVANS & SON 8802 Harford road						MAY 2 1969		Charles Judge	

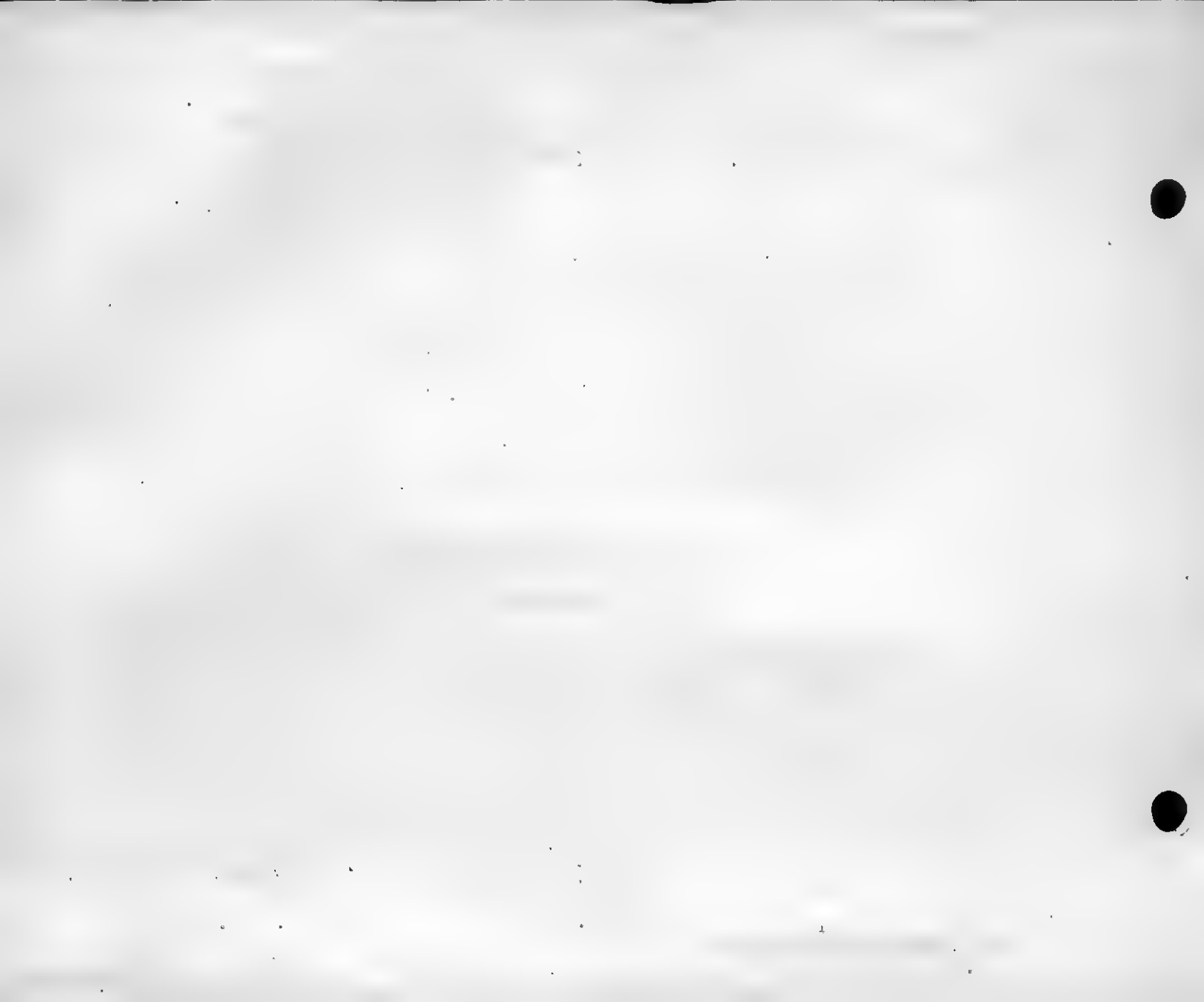


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year		2b. HOUR	
Louis C. Kafer						April 9, 1969		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		CAUCASIAN		DEC. 27, 1916		52 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND			USA					Baltimore Md	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)	
SPARROWS PT. 21219				Beth Steel Sp. Pt. Hosp.				YARDMASTER RAILROAD	
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 15?	
Md.				Balto.		DUNDALK		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
AUGUST KAFER				MAGADELENA MARKEL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
NO				213-09-4127		ANNA K. KAFER AS IN # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive Cardio-vascular disease</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.B. Davis		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		M.B. Davis MD-6800 MORNISTOWN		ADDRESS Street City State or County		Dundalk Md - 21222		4-9-69	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		11 APRIL 69		GRDNS. FAITH		BALTO. CO., MD			
24. FUNERAL DIRECTOR				25a. REC'D BY REG. STRAR				25b. REGISTRAR'S SIGNATURE	
W. BROOKS BRADLEY				DUNDALK, MD. 21222				APR 11 1969	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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05084

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05076

1. DECEASED NAME (Type or Print) JOHN M. KLASKA		First Middle Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 7 DAY 7 YEAR 1969		2b. HOUR 5:00 PM	
3. SEX M	4. RACE W	5. DATE OF BIRTH 4/20/07	6. AGE (in years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 4 Day 7 Year 1969	
7a. BIRTHPLACE (State or foreign country) OHIO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 519 WELLBROOK AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME JOHN M. KLASKA		First Middle Last		15. MOTHER'S MAIDEN NAME UNK		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK		16b. SOCIAL SECURITY NO 029-05-8779		17. INFORMANT KAFKA ADDRESS EDITHE KLASKA		17b. ADDRESS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF (b) A-S-C-V-DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 4/10/69 HOUR A.M. 10 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. 6800 HORNINGTON RD		City or Town BALTO. County MD. State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/10/69	
EXAMINER'S NAME (Type) MELVIN B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) 6800 HORNINGTON RD 21222			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/10/69		23c. NAME OF CEMETERY OR CREMATORY MORELANDS		23d. LOCATION (City or Town) BALTO. (County) MD. (State)	
24. FUNERAL DIRECTOR J. G. CONNELLY SONS		ADDRESS 300 MACE		25a. REC'D BY REGISTRAR APR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH Item 2 Film 412 5/1/69K									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05085					05077				
CERTIFICATE OF DEATH									
1. PLACE OF DEATH Baltimore a. COUNTY CATONSVILLE 28 MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CATON RIDGE NURSING HOME					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville Baltimore 21230 d. STREET ADDRESS 2030 Whistler Avenue 89 HARLEM LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last CLARA KARL 4. DATE OF DEATH Month Day Year APRIL 20 1969					5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 213-18-0473-A					11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Griffin					14. MOTHER'S MAIDEN NAME Clara Sinclair				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 213-18-6473-A 17. INFORMANT Address 21230 Caton Ridge Nursing Home - 329 Harlem Lane					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis (CVA) 4301 } DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 11-21-1967 to 4-20-1969, that (I) (we) last saw the deceased alive on 4-20-1969, and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE Cesar Valle Caveru					22b. DATE SIGNED 4-21-69				
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERU					22d. ADDRESS 8629 Liberty				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 4/24/69				
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery					23d. LOCATION (City, town or county) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., Balto., Md. 21229					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

05086		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05078	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR
Anna		Bertha	Kasten		April Month 14 Day 1969 Year		5:03 P M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR	
Female	Cauc		1-27-93		86 YRS.	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland	USA				Baltimore Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Shangra-LA Nurse, Home, Catonsville, Md.		Unknown			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER	
Maryland		—		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	Uplands Apts Mavordene Road	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		
William		Kasten			Julia Houch		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT			
NO		212-07-782		Arthur G. Leutner 2107 Southland Rd Balt 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Pneumonia							6 days
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular accident							3 days
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular Disease							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Anemia Urinary Tract Infection							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		HOUR A.M. Month Day Year P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from 9 NOV, 1967, to April, 1969, that (1) (we) last saw the deceased alive on 14 April 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Richard R. Stephenson, M.D. DEGREE						14 April 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
				1302 Crofton Road Balt. Md 21212			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Entombment		4-17-69		Lorraine Mausoleum		Baltimore, Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ARMACOST		4600 LIBERTY Hgts Md		APR 17 1969		Charles Judge	

11-11-11

11-11-11

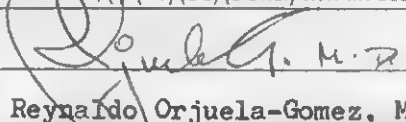

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Alice		Middle L.		Last Kearfott		2a. DATE OF DEATH Month April Day 6 Year 1969		
3. SEX Female		4 RACE White		5. DATE OF BIRTH 4-26-05			6 AGE (In years lost birthday) 63 YRS		2b. HOUR 4:15 M		
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 115 Hydes, Maryland			
14 FATHER'S NAME First Benjamin Middle Johnson Last Chamberlein			15 MOTHER'S MAIDEN NAME First Mary Middle Howard Last Howard								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If give war or dates of service) 213-20-1303		17 INFORMANT Address M. Munroe Holley Box 422 Kingsville Md							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction											
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery thrombosis											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that he (this hospital) attended the deceased from 3-25 , 19 69 , to 4-6 , 19 69 , that he (we) last saw the deceased alive on 4-6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.											
22b. SIGNATURE 		DEGREE Reynaldo Orjuela-Gomez, M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-7-69					
22d. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22e. ADDRESS 7620 York Road, Towson, Maryland 21204									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/9/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Leonard J Ruck Inc		ADDRESS Baltimore, Maryland		25a. REC'D BY REG STRAR APR 8 1969		25b. REGISTRAR'S SIGNATURE 					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

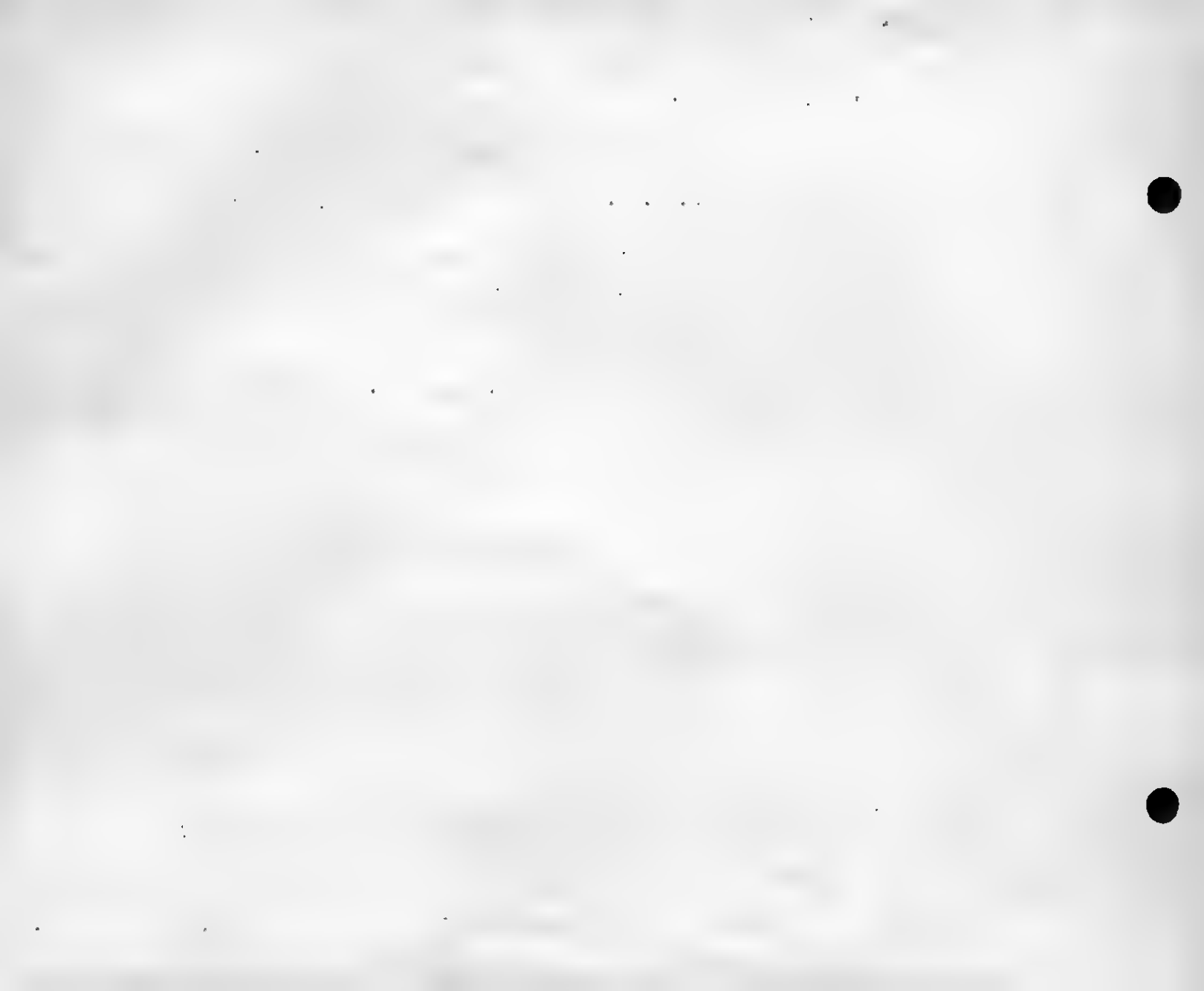
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05088											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR			
MARGARET E KENNEDY			APRIL		Month Day Year		5, 1969		9:38 AM		
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		2-4-1899		70 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR IND. STRY			
TOWSON 4			ST. JOSEPH HOSPITAL			Retired		Telephone operator			
13a USUAL RESIDENCE (Where deceased lived; if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d NO. OF CITY LIMITS?		13e STREET AND NUMBER		
MARYLAND			13b COUNTY		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6112 MAYWOOD AVE. #21209		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Thomas Donohue			Bridgett								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown)			16b SOCIAL SECURITY NO		17 INFORMANT		Address				
no			219-18-9786		Thomas J. Kennedy, Jr.		same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest and brain damage											
DUE TO, OR AS A CONSEQUENCE OF Acute extensive myocardial insufficiency											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease and diabetes mellitus											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION		Street or R.F.D. No.		City or Town		County State	
22a I certify that (this hospital) attended the deceased from 4-4-69, 1969, to 4-5, 1969, that (we) last saw the deceased alive on 4-5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death											
22b SIGNATURE		DEGREE				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED			
Jaime M. Punzalon								April 5, 1969			
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS									
Jaime M. Punzalon, M.D.		7620 York Road, Towson 4, Md.									
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
burial		4/8/69		St. Johns Cemetery		Long Green		Balto.		Md.	
24 FUNERAL DIRECTOR		ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Mitchell-Wiedefeld Home		6500 York Rd. Balto., Md. 21212				APR 9 1969		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05089 Item 5 Film 412 5/2/69 kk									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
WILLIAM JAMES KILGORE JR.						4 Month 26 Day 69 Year			10:40
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE	WHITE		February 26, 1917			58 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
LANCASTER, PA.		U. S. A.				BALTIMORE, Co.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
TOWSON		GREAT. BALT. MED. CEN.		Supervisor		Advertising			
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Baltimore		Carney				9618 Harford Road 21234	
14. FATHER'S NAME			First Middle Last			15. MOTHER'S M A DEN NAME			First Middle Last
WILLIAM J. KILGORE SR.						Esther			Trout
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address	
No						Mrs. Thelma M. Kilgore		9618 Harford Road	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC BRONCHOGENIC									
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from MARCH 28, 1969, to APRIL 26, 1969, that (I) (we) last saw the deceased alive on APRIL 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
D. G. Caralis M.D.		4/26/69			Dr. Dionyssios G. Caralis, M.D.		6701 N. Charles St. 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/29/69		Glen Haven Memorial Pk		Glen Burnie, Md. A.A. Co.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
M. Cully F.H.		237 Patapsco Ave. 21225			APR 29 1969				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 16&22a Film 412 MARYLAND STATE DEPARTMENT OF HEALTH
5-14-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0508

05090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) ALVA		First Alva		Middle Cletus		Last KINSEY		2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year		2b HOUR 6:45A	
3 SEX Male	4 RACE White	5. DATE OF BIRTH March 11, 1923	6. AGE (in years last birthday) 46 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c DATE PRONOUNCED DEAD Month April Day 11 , Year 1969		2d HOUR 6:45A	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore					
10 CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Spring Grove Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck Driver		2b KIND OF BUSINESS OR INDUSTRY Plumbing Co.					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Balto.		13c CITY OR TOWN Balto.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1703 W. Hollins Street			
14. FATHER'S NAME First Cletus B. Kinsey				Middle 				Last 			
15 MOTHER'S MAIDEN NAME First Mabel J. Howe				Middle 				Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO. 216-16-2656		17. INFORMANT Family records				ADDRESS 			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary tuberculosis and arteriosclerotic cardiovascular disease											
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f. LOCATION Street or R.F.D. No. 		City or Town 		County 		State 	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Ronald N. Kornblum				M.D. 				22b. DATE SIGNED 4/11/69			
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				ADDRESS (Street, city, town, or county) 							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland				ADDRESS 				25a. REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE R. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

650521

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05083

Item 5 Film 412 5/19/69 kk

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Louis Kirsh		Middle Kirsh		Last Kirsh		2a. DATE OF DEATH 4 Month 26 Day 69 Year		2b. HOUR 1:30 AM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MARCH 21/87		6 AGE (in years last birthday) 1877 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retail		12b. KIND OF BUSINESS OR INDUSTRY Produce Broker			
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8827 Allenswood Rd.	
14. FATHER'S NAME First Middle Last Moses Kirsh		15. MOTHER'S MAIDEN NAME First Middle Last Jennie ?		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Unknown					
16b. SOCIAL SECURITY NO		17. INFORMANT Address Hospital records, Randallstown, Md.							
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC GANGRENE OF BOTH LEGS 4124 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 4-17-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE, LEFT LEG		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/11/69 , 19 69 , to 4/26/69 , 19 69 , that (I) (we) last saw the deceased alive on 4/25/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Joel Malabrigo		22c. DATE SIGNED 4-26-69		22d. PHYSICIAN'S NAME (Type) Dr. Joel Malabrigo		22e. ADDRESS Balto. Co. Gen. Hosp Randallstown, Maryland 21133		22f. REGISTRAR'S SIGNATURE James Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 27, 1969		23c. NAME OF CEMETERY OR CREMATORY Agudas Achim Anshe Sfard		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		23e. RECORD BY REGISTRAR APR 30 1969	
24. FUNERAL DIRECTOR Sol Levinson & Bros. 3010 Reisterstown Road									

FOR STATE
HEALTH DEPT.

05092

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05084

1. DECEASED NAME (Type or Print) Melvin		First L.		Middle L.		Last Kitzmiller Sr.		2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/> 4/28 1969		2b. HOUR 9:07 AM	
3 SEX Male	4 RACE White	5. DATE OF BIRTH Dec. 8, 1918		6. AGE (In years last birthday) 50 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input checked="" type="checkbox"/> April 28 1969	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore					
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2405 Meadow Road				12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Foreman-City of Baltimore				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, on residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2405 Meadow Road			
14. FATHER'S NAME First Robert L. Middle Kitzmiller Last Kitzmiller				15. MOTHER'S MAIDEN NAME First Lillian Middle Berry Last Berry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes, give year or dates of service) WWII		17. INFORMANT (Wife) Mrs. Catherine Kitzmiller, 2405 Meadow Rd.				ADDRESS Dundalk, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4/29 Acute Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input checked="" type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Theodore C. Patterson		EXAMINER'S NAME (Type) Theodore C. Patterson		M.D. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/3/69		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) Bel Air, Maryland		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				ADDRESS		25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE Michaela Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be excluded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

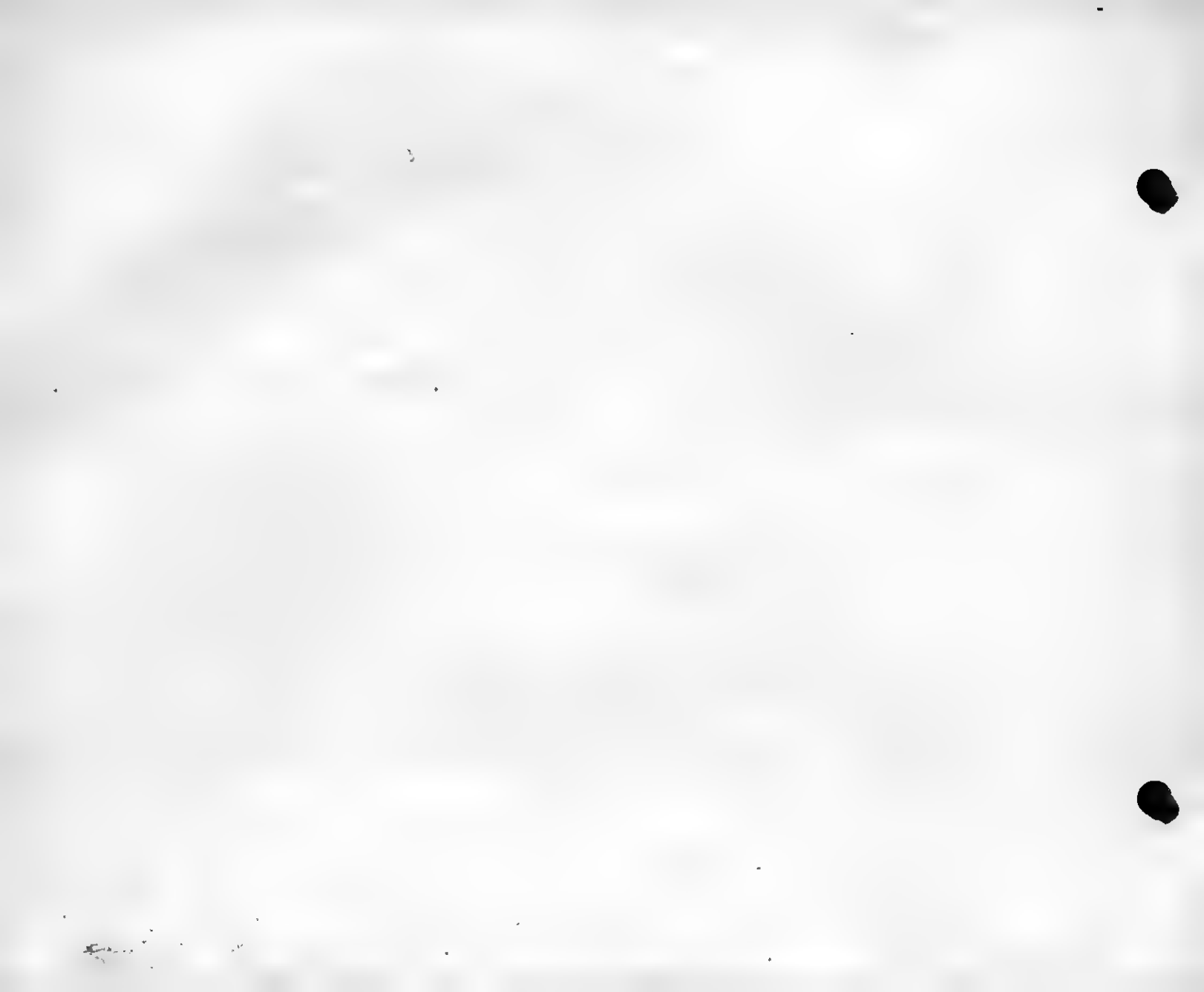
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05093		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05085	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
ELVINA					Klauberger	April 10 1969 4 P.M.	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER YEAR MONTHS DAYS HOURS MIN	
Female	White	1-23-1881		88 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Missouri	U.S.A.			Baltimore			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during last year, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Garrison, Md.		Foxleigh Nursing Home		Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Baltimore		Cockeysville		609 Cranbrook Rd.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
--			Summers			Unobtainable	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address		
			492-09-4510		Home Records		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:							
4369 IMMEDIATE CAUSE (a) Coronary Vascular Accident							18 hours
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis							years
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Arteriosclerotic Heart Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
		19					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 1, 1967, to April 10, 1969, that (I) (we) last saw the deceased alive on April 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David I. Miller				22c. DATE SIGNED 4-10-69			
22d. PHYSICIAN'S NAME (Type) David I. Miller				22e. ADDRESS 9015 Reisterstown Rd. Owings Mills, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Removal		4/11/69		St. Peters Cemetery		St. Louis County, Mo.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
The S.H. Hines Co.		2901 14th ST. N.W.		APR 14 1969		Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) MAX			First MAX Middle KLEINER Last KLEINER			2a. DATE OF DEATH Month APRIL Day 8 Year 1969			2b. HOUR 12:50 A.M.
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 09/16/08		6. AGE (In years last birthday) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (State or foreign country) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Md.
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Da Ho. Co. GEN. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BOOKBINDER/MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b. COUNTY BALTO		13c. CITY OR TOWN RANDALLSTOWN		13d. INSIDE CITY LIM. IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3103 Donna Rd	
14. FATHER'S NAME First Benjamin Middle Kleiner Last 			15. MOTHER'S MAIDEN NAME First BELLA Middle Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 		17. INFORMANT Address XXXX MRS. DOROTHY KLEINER, 3103 DONNA RD. #7					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR 10 XS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (1) (this hospital) attended the deceased from 1960 , to 4/7 , 1969, that (1) (we) last saw the deceased alive on 4/7 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard R. Shochet, MD				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/8/69			
22d. PHYSICIAN'S NAME (Type) BERNARD R. SHOCHET				22e. ADDRESS 6804 PARK HEIGHTS AVE, BALTO-15					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-8-69		23c. NAME OF CEMETERY OR CREMATORY SWINITCHER WOLINER BENEVOLENT ASSOC., BALTIMORE, MD.			23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.				25a. REC'D BY REGISTRAR APR 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR				
CURVIN			LUTHER			KLING			Month Day Year 1969				
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		
Male			White		Dec. 91 1903		65 YRS		MONTHS 3 DAYS 29		HOURS		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Penna.			U. S. A						BALTIMORE				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
			Greater Baltimore Medical Center						Retired Farmer				
13a USUAL RES.DENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Md.			Baltimore			Towson			YES <input type="checkbox"/> NO <input type="checkbox"/>		105 Shealey One		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT	
John			Kling			Ida			Jacobs			ADDRESS R. D. # 3	
												Spring Grove, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute necrotizing esophagitis with</u>													
5501													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <u>abscess formation and left em. ema</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?				
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			HOUR A.M. P.M. 19										
22a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			22c LOCATION Street or R.F.D. No. City or Town County State							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						April 9, 1969				
Charles S. Springate, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			Apr. 12, 1969			Mt. Zion Cemetery			York, R.D. York, Pa.				
24 FUNERAL DIRECTOR			25a REC'D BY REG. STRAR						25b REGISTRAR'S SIGNATURE				
James Hartenstein, New Freedom, Pa.			APR 14 1969						Charles Judge				

05096

CERTIFICATE OF DEATH

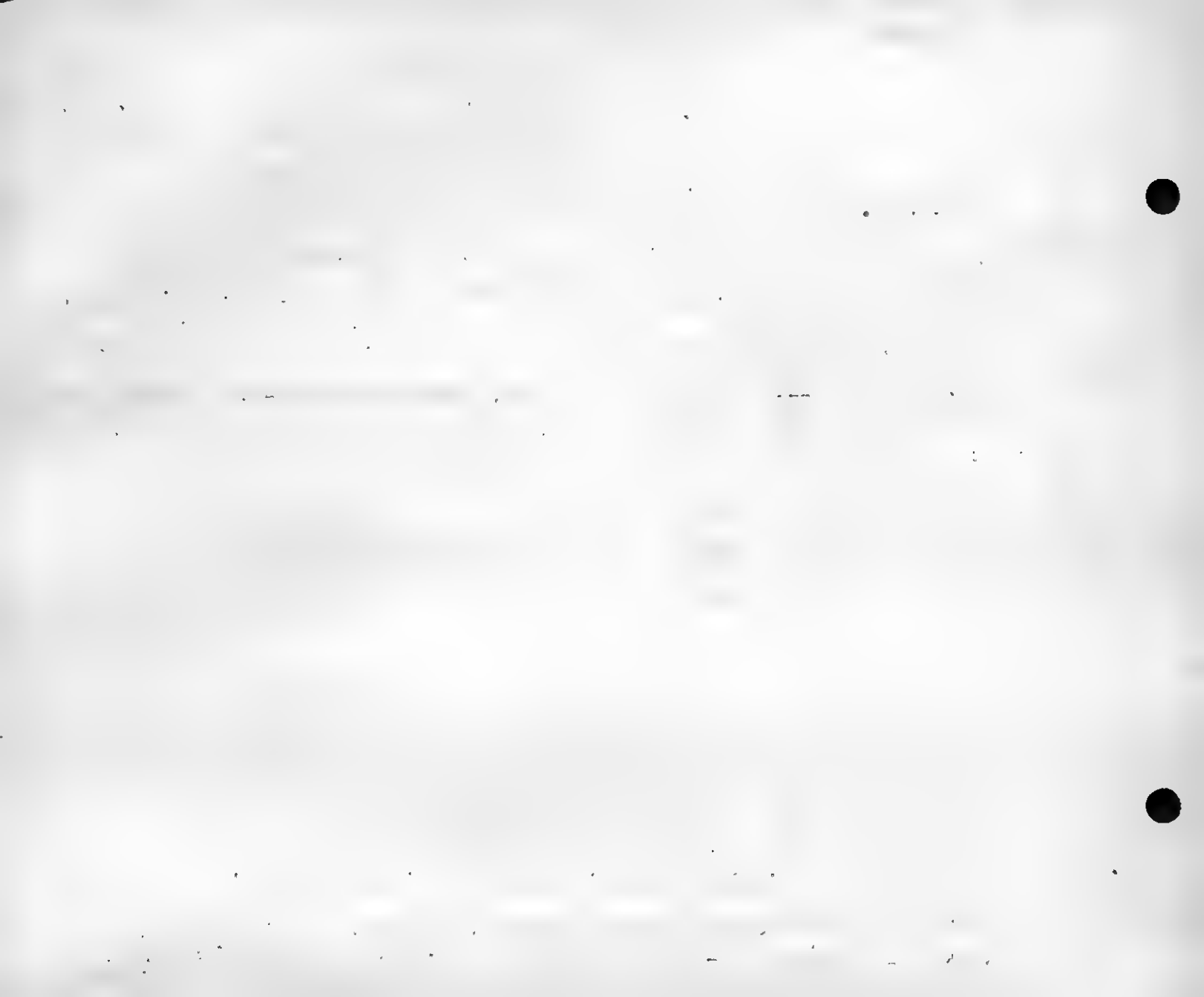
05088

1. DECEASED-NAME (Type or print) <i>Mary K. Kraitz</i>			2a. DATE OF DEATH Month <i>4</i> Day <i>10</i> Year <i>69</i>			2b. HOUR <i>7:20 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>3/2/1889</i>		6. AGE (In years last birthday) <i>80</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore Co.</i> Md.	
10. CITY OR TOWN OF DEATH <i>Balto.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holmes & Narving Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>6012 Loch Raven Blvd.</i>		14. FATHER'S NAME First <i>Henry</i> Middle <i>E. J.</i> Last <i>Smith</i>		15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Wirth</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>Mrs. John McQuade, Jr.</i>		Address <i>941 Ellendale Drive 4</i>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Vulva</i> <i>1841</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1-year</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>68</i> , to <i>April</i> , 19 <i>69</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>April</i> , 19 <i>69</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (<i>we</i>) (<i>did</i>) (<i>did not</i>) view the body after death.							
22b. SIGNATURE <i>J. F. Palmisano</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-13-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Joseph F. Palmisano M.D.</i>		22e. ADDRESS <i>6608 Loch Raven Blvd.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/14/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadow Ridge Mem. Park Cem.</i>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home</i>		ADDRESS <i>6500 York Rd. 21212</i>		25a. REC'D BY REGISTRAR <i>APR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113
ISM 113

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05097									
CERTIFICATE OF DEATH									
05089									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mabel E. Krause						Month Day Year April 14 1969			M
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last b rthday)		IF UNDER 1 YEAR MONTHS DAYS	
F		W		10/30/1892		76 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Balto., Md.		U.S.A.				Baltimore Md			
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Towson		Armacost Nursing Home		Retired Secretary		State Roads			
13a. USUAL RESIDENCE (Where deceased lived, if inst lrt on admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		N		Baltimore				3939 Roland Ave.	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John Jacob Krause			Katie E. Unkelback						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17. INFORMANT				
No			214-01-1868		Miss Ruth Lackner, 3311 Woodstock Ave				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Carcinoma Pelvis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Metastasis to Colon</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21a. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION		Street or RFD No		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from April 1, 1969, to April 14 1969, that (I) (we) saw the deceased alive on April 14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Dr. Laurence C. Post					4/15/69				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Dr. Laurence C. Post					6805 York Road				
23a BURLIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		4/17/1969		Baltimore		Baltimore Md.			
24. FUNERAL DIRECTOR					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					APR 17 1969		J Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Charles			G. Lamley			Month 4 Day 24 Year 69		11:30 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Male		White		11/28/90		78 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U. S.				Baltimore County Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			Spring Grove State Hosp.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			136		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2683 St. Benedict St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
			216-02-2905			Records-Spring Grove State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Nephrosclerosis - Uremia										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Atherosclerosis C.V. disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Generalized Atherosclerosis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Bronchopneumonia, bilateral										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>										
22a. I certify that (X) (this hospital) attended the deceased from 3/25/66, 19__, to __, 19__, that (X) (we) last saw the deceased alive on __, 19__, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did) not view the body after death										
22b. SIGNATURE						22c. DATE SIGNED				
ALBERTO M. GUTIERREZ M.D.						4-24-69				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
						Spring Grove State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			4/28/69		Lorraine Park Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Witzke, 4101 Edmondson Ave., 21229						DATE APR 29 1969		Charles Judge		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print) <i>Anthony Joseph Lepinski</i>			First Middle Last			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>Apr 3 1969</i>		2b. HOUR <i>2:30</i> M	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>2-11-1884</i>	6. AGE (in years as of birthday) <i>85</i> YRS	7. UNDER 1 YEAR MONTHS	8. UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD Month <i>Apr</i> Day <i>3</i> Year <i>1969</i>		2d. HOUR <i>4:20</i> M	
7a. BIRTHPLACE (State or foreign country) <i>Poland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md			
10. CITY OR TOWN OF DEATH <i>White Marsh, Md</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>910 Alexander Rd</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>BALTO</i>			13c. CITY OR TOWN <i>White Marsh, Md</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME First <i>Joseph</i> Middle <i>Henry</i> Last <i>Levin</i>			15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Levin</i> Last <i>Levin</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16b. SOCIAL SECURITY NO <i>28-05-630</i>			17. INFORMANT ADDRESS <i>Antoinette K. Twinkie - 910 Alexander Rd</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>9</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE: <i>John C. Hyle</i>			EXAMINER'S NAME (Type) <i>JOHN C. HYLE</i>			22b. DATE SIGNED <i>4-3-69</i>		ADDRESS (Street, city, town, or county) <i>737 Butler Rd Baltimore</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4-7-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>HOLY BOEARY CEM.</i>		23d. LOCATION (City or Town) <i>DUNDALK MD</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>John M. Webery Sons Inc.</i>			ADDRESS <i>401 S. CHESTER</i>			25a. REC'D BY REG. STRAR <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>John C. Hyle</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Stephen		Middle B.		Last Lating		2a DATE OF DEATH Month Day Year April 28, 1969		
3 SEX male		4 RACE white		5 DATE OF BIRTH July 10, 1892			6 AGE (In years last birthday) 76 YRS.		2b HOUR 11:30 a. M.		
7a BIRTHPLACE (State or foreign country) Illinois		7b CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md					
10 CITY OR TOWN OF DEATH Catonville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) carpenter			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Balto.		13c CITY OR TOWN Dundalk		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 59 Northship Road		
14. FATHER'S NAME First Middle Last Stephen Lating			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Boeing								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			16b SOCIAL SECURITY NO. 213-07-5514A		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Right ventricle wall rupture</u> 486X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Left ventricle wall rupture</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from April 8, 1969, to April 28, 1969, that (I) (we) lost the deceased alive on April 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Rafael H. Marin</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-28-69							
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Md. 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/1/69		23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Cemetery			23d. LOCATION (City or Town) Dorsey, Md.		(County) (State)		
24. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 1 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1-11-69
45M 1-11-69

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05101		CERTIFICATE OF DEATH						05093		
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
Thomas George Lawrence						April 29, 1969			3:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
male		white		May 18, 1877			71 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.	
Md.		U. S.				Baltimore				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville			SPRING GROVE STATE HOSP.			landscape gardener				
13a. USUAL RESIDENCE (Where deceased lived if institution Res. den. before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. 207 W. 11th St. Brooklyn	
Md.			Balto.		Halethorpe		YES <input type="checkbox"/> NO <input type="checkbox"/>		207 W. 11th St. Brooklyn	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Lawrence			Matilda Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			Maryland Naylor - 145 W. 11th St. Owings		
NO			214-14-1482		Records: SPRING GROVE STATE HOSPITAL			Mills		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Dehydration</i>										
DUE TO, OR AS A CONSEQUENCE OF <i>Chronic heart failure</i>										
(b) <i>Chronic heart failure</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Dehydration</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year								
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		City or Town		County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		Street or R.F.D. No						
22a. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1960, to April 29, 1969, that (I) (we) last saw the deceased alive on April 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Rafael H. Marin</i>						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type)						22c. DATE SIGNED		4/30/69		
Rafael H. Marin, M.D.						22e. ADDRESS		SPRING GROVE STATE HOSPITAL		
						Baltimore, Maryland		21228		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		5-2-69		Woodlawn Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ADDRESS						DATE		MAY 2 1969		
Armacost Funeral Chapel-4600 Liberty Hts								<i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05102

05094

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
ANNA		JOSEPHINE	LE	BRUN	April Month 5 Day 1969 Year		11:45 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS
Female		White		5-4-1892		76 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		USA				Baltimore Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph's Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) - STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Baltimore						7138 Greenwood Rd. 21236
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Frank				Kalal	Anna			Kreck
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address		
No				212-10-1146B		Charles E. Le Brun 7138 Greenwood Ave 21236		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infarction of small bowel								
DUE TO, OR AS A CONSEQUENCE OF (b) Portal vein thrombosis								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
4-2-69/4-5-69		Gastropexy - Exp. lap.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from March 29, 1969, to April 5, 1969, that (X) (we) last saw the deceased alive on April 5, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
Samuel Lee, M.D.						4-6-69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Samuel Lee, M.D.		7620 York Road, Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4-9-1969		Gardens of Faith		Baltimore Co. Md.		
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Lassahn Funeral Home 7401 Belair Road 21236				APR 10 1969		[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05103

CERTIFICATE OF DEATH

05095

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Antionette				Lehman	April 28, 1969		2:30 PM		
3. SEX	4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		
female	white		Jan. 3, 1889		80 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Germany	U. S.				Baltimore				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPATION (Kind of work done during most of work life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Catonsville		SPRING GROVE STATE HOSP.		housewife		HOME			
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		Pr. Geo.		Mt. Rainier				4200 - 31st Street	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17. INFORMANT	
First Middle Last		First Middle Last						Address	
Jacob REINERS		Gertrude UNKNOWN						Records: SPRING GROVE STATE HOSPITAL	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death								10 mins.	
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular Mt. Dis.								5 yrs. +	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Arteriosclerosis, Generalized, senile.								5 yrs. +	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Chronic Brain Syndrome and senility.									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (this hospital) attended the deceased from April 9, 1964, to April 28, 1969, that (we) last saw the deceased alive on April 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE				22c. DATE SIGNED					
[Signature]				4-28-69					
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS					
Anthony J. Young, M.D.				SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		5-2-69		Arlington Natl		Arlington Va.			
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Dehitt Donaldson				MAY 6 1969		[Signature]			

05104

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) ANNE BAKER LEIMBACH			2a. DATE OF DEATH April Month 9 , Day 1969 Year			2b. HOUR M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH August 23, 1895		6. AGE (In years lost birthday) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md				
10. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) Hampton House Apts.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Owner, Dress Shop			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 204 E. Joppa Road	
14. FATHER'S NAME First Middle Last Henry F. Baker			15. MOTHER'S MAIDEN NAME First Middle Last Cora Warman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Herbert J. Leimbach, Jr. Keys. Village of Cross 21210					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 B. Pulchopneumonia. DUE TO, OR AS A CONSEQUENCE OF (c) chronic arterial hypertension									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDINGS, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11/11 , 19 68 , to 4/8 , 19 69 , that (I) (we) lost the deceased alive on 4/8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Jam and Jamel					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/10/69.			
22d. PHYSICIAN'S NAME (Type) JAMSHID HAMED MD.					22e. ADDRESS TOWSON 8 MD.					
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE Apr. 11, 1969		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			23d. LOCATION (City or Town) (County) (State) Pikesville, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204					25a. REC'D BY REGISTRAR APR 14 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 45M 16 69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05105 CERTIFICATE OF DEATH 05097									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Margaret W. Lescekauskas						April Month 28 Day 1969		850 P. M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
F		W		Nov. 1, 1888		80 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Lithuania		U. S. A.				Baltimore			
1d. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		Shady Nook Nursing Home		Housewife					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Anne Arundel		Glen Burnie				400 Delaware Avenue 21061	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If give war or dates of service)		17 INFORMANT		Address		21061	
No		218-01-2245		Emily Glessner		400 Delaware Ave.		Glen Burnie	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, recurrent</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Arteriosclerotic CVD</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u></u>									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>10 days</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>68</u> , to <u>4/28</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/27</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED			
<u>Herbert J. Levickas</u>		Herbert J. Levickas		5404 East Drive Baltimore 21227		4/29/69			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5-2-69		Most Holy Redeemer		Belair Rd. Baltimore Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE			
Howard H. Hubbard 4107 Wilkens Ave. 21229				DATE MAY 1 1969					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 13 Filled 12 4/30/69 kk 05106										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05098			
1 DECEASED-NAME (Type or Print) <i>Reuben</i> First Middle Last										2a DATE KNOWN OF DEATH <input type="checkbox"/> EST. <input type="checkbox"/> MATED <input type="checkbox"/> 4-21-1969										2b HOUR 6:30 P.M. 2d HOUR 7:00 P.M.			
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>MARCH 15, 1909</i>		6 AGE (In years last birthday) <i>60</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 19											
7a BIRTHPLACE (State or foreign country) <i>NEW YORK CITY</i>				7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH <i>Baltimore</i>											
10 CITY OR TOWN OF DEATH <i>BALTIMORE</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>IN AUTOMOBILE IN FRONT OF 7914 SUBET ROAD</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>CAR DRIVE</i>				12b KIND OF BUSINESS OR INDUSTRY <i>CHAUFFEUR</i>											
13a USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) STATE <i>MARYLAND</i>				13b COUNTY <i>Baltimore</i>				13c CITY OR TOWN <i>Randallstown</i>				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER <i>8416 DOWNEY DALE DRIVE</i>							
14 FATHER'S NAME First Middle Last <i>JACOB LEVENBERG</i>					15 MOTHER'S MAIDEN NAME First Middle Last <i>SARAH ?</i>																		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>X YES</i>					16b SOCIAL SECURITY NO <i>W.W. II 216-03-4403</i>					17 INFORMANT ADDRESS <i>7914 MRS. ANNETTE LENENBERG, c/o XXXX SUBET ROAD</i>													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bullet wound (extreme) of head</i> 15.5V DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>Had been depressed at least past 1 month</i>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month Day Year <i>4-21-69</i> HOUR A.M. <i>6:30-7:00 AM</i>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)															
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>7914 Subet Rd Baltimore County</i>				21f LOCATION Street or RFD No City or Town County State															
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <i>Robert B. Taylor MD</i>				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>4-21-69</i>											
ADDRESS (Street, city, town, or county) <i>700 Cathedral St.</i>																							
23a. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>				23b DATE <i>4-22-69</i>				23c NAME OF CEMETERY OR CREMATORY <i>BETH EL MEMORIAL PARK</i>				23d. LOCATION (City or Town) (County) (State) <i>RANDALLSTOWN, MARYLAND</i>											
24. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>										25a. REC'D BY REGISTRAR DATE <i>APR 23 1969</i>				25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item #23a, b, c, d DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Film #G412 5/9/69 vpw 05107 CERTIFICATE OF DEATH

05099

1. DECEASED-NAME (Type or print)		First Clinton	Middle	Last Lewis	2a. DATE OF DEATH Month Day Year April 26, 1969		2b. HOUR 12:35 a.		
3. SEX male	4. RACE white		5. DATE OF BIRTH Aug. 31, 1901		6. AGE (in years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) salesman		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Gwynn Oak		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1928 Englewood Avenue	
14. FATHER'S NAME First Middle Last Ralph Clayton Lewis				15. MOTHER'S MAIDEN NAME First Middle Last Nina Hallstead					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 202-01-2954A		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, death. 10 mins. 4107 DUE TO, OR AS A CONSEQUENCE OF with previous myocardial infarct. (b) Arteriosclerotic cardiovascular ht. dis. 10 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, generalized, senile 10 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Alcoholism, chronic, 10 yr. history of.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from March 26, 1969, to April 26, 1969, that (X) (we) last saw the deceased alive on April 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Anthony J. Young</i>				22c. DATE SIGNED 1-29-69		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
22d. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22e. ADDRESS Balto.		22f. REC'D BY REGISTRAR MAY 6 1969		22g. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE May 6, 1969		23c. NAME OF CEMETERY OR CREMATORY Anatomy Board of Md.		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR ADDRESS Newell Funeral Home, Reisterstown Rd.		24a. BALTO. MD.		24b. DATE MAY 6 1969		24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last Lichtenberg, nmi (Burt) BURTON					2a. DATE OF DEATH Month Day Year 4 4 69		2b. HOUR 30am		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-29-27		6. AGE (In years lost birthday) 41 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Norfolk, Va		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto. Co.			
10. CITY OR TOWN OF DEATH Randallstown, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) B.C.G.H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY WHOLESALE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 6822-C Townbrook Dr.	
14. FATHER'S NAME First Middle Last Samuel Lichtenberg					15. MOTHER'S MAIDEN NAME First Middle Last Pearl nmi Miller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 212-28-3174		17. INFORMANT Address MR. HERBERT LICHTENBERG, 3421 WASHINGTON AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) metastatic lymphosarcoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2001								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/10/63 , 19 63 , to 4/3 , 19 69 , that (I) (we) last saw the deceased alive on 4/3 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Milton Schlenoff MD					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/4/69		
22d. PHYSICIAN'S NAME (Type) Milton Schlenoff					22e. ADDRESS 6410 WINDSOR MILL ROAD				
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE 4-6-69		23c. NAME OF CEMETERY OR CREMATORY BETH JACOB		23d. LOCATION (City or Town) (County) (State) FINKSBURG, MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					25a. REC'D BY REGISTRAR APR 9 1969		25b. REGISTRAR'S SIGNATURE William J. Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First William		Middle C.		Last Lilly		2a. DATE OF DEATH Month Day Year April 12, 1969	
3 SEX M		4 RACE W		5. DATE OF BIRTH 1-14-1881			6 AGE (in years last birthday) 88 YRS.		2b. MOJR 335 M	
7a BIRTHPLACE (State or foreign country) Philadelphia,			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md		
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holly Hill Manor N. H. Ret'd			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) Foundryman			12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) Maryland			13b COUNTY BALTO		13c CITY OR TOWN Balto. 21212		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 810 Winston Avenue	
14 FATHER'S NAME First Middle Last William C. Lilly			15. MOTHER'S MAIDEN NAME First Middle Last Annetta Irving							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO 043-05-5363A		17 INFORMANT Mrs. Charles T. Coard			Address 810 Winston Ave		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State		
22a I certify that (I) (this hospital) attended the deceased from April 1, 1969, to April 12, 1969, that (I) (we) last saw the deceased alive on April 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Laurence C. Post		22c DATE SIGNED 4/14/69		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post		22e ADDRESS 6805 York Road								
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 4-17-69		23c NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d LOCATION (City or Town) St. Petersburg, Fa.		(County) (State)		
24 FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md.		25a. REC'D BY REGISTRAR DATE APR 14 1969		25b REGISTRAR'S SIGNATURE Charles Judge				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form FMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FINER

VR A15ME (5)
10M REV 1/68

<div style="display: flex; justify-content: space-between;"> 05110 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05102 </div> <h2 style="margin: 0;">MEDICAL EXAMINER'S CERTIFICATE OF DEATH</h2>											
1 DECEASED NAME (Type or Print) <div style="display: flex; justify-content: space-between; margin-top: 5px;"> First NORMA Middle EDITH Last LUCY </div>						2a. DATE KNOWN OF DEATH <div style="display: flex; align-items: center;"> <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year </div>			2b. HOUR M		
3 SEX female		4 RACE white		5 DATE OF BIRTH 11-26-23		6 AGE (in years last birthday) 45 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland						7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Baltimore						11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 2902 Michigan Avenue				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before 1969) Maryland						13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2902 Michigan Avenue	
14. FATHER'S NAME First Middle Last Joseph M. Heyler				15. MOTHER'S MAIDEN NAME First Middle Last Edith Lindenaer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 317-46-3275		17. INFORMANT ADDRESS Howard W. Lucy - 2902 Michigan Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot Wound of Neck DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR 4:40 PM 4/14 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subj. shot self in neck							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No City or Town County State 2902 Michigan Avenue, Baltimore, Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 4/15/69			
EXAMINER'S NAME (Type) Werner U. Spitz M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/18/69		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR George L. Schwab - 2161 Fredrick				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 18 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05111 1 Item 10 Film 411 4/23/69 kk											
05103											
1. DECEASED NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR			
First Middle Last						Month Day Year		M			
DOLORES R. LYNCH						4/16/69					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (If years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
Female		White		April 12, 1915		54 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore County Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				1523 Clearwood Road				Housewife		None	
13a. USUAL RESIDENCE (Where deceased admisson) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Baltimore				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1523 Clearwood Road	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
James Shipley				Regina Rose Herrlich							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No				None		Walter H. Lynch 6530 Franklin Road					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Negative Coma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>1 yr</u>											
(c) <u>Breast Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>2 yrs</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (U) (this hospital) attended the deceased from <u>July 6, 1968</u> to <u>April 19, 1969</u> , that (U) (we) last saw the deceased alive on <u>4/10/69</u> 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (U) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Raymond D. Barran</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>4/16/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>RAYMOND D. BARRAN</u>						22e. ADDRESS <u>51 Argo Ave</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		4-19-69		HAMPSTEAD CEMETERY		Hampstead Carroll Co. Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. FILED BY REGISTRAR			
William E. Johnson 8521 Loch Raven Blvd.						APR 17 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05112 CERTIFICATE OF DEATH 05104									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P M
Frank F. Maddox						April 10, 1969			1:05 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
Male		Negro		May 29, 1900		68 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEP <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA		Sep <input checked="" type="checkbox"/>		Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson			St. Joseph Hospital			LETITIA LITV MAY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS. DE. CITY LIM. TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1500 E. Chase St. #21213
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
FRANK			MADDOX			LAURA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
NO					DAISY MADDOX 1839 E LAFAYETTE				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Intractable Congestive Heart Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Myocardial Infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 14, 1969</u> to <u>April 10, 1969</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 10</u> 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
<u>Tomboc</u>							April 10, 1969		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Camilo Tomboc, M.D.					7620 York Road Baltimore, Md. 21204				
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4-15-69		MT-AUBURN		BALTIMORE Md			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
JOSEPH KNIGHT 1639 N. BROADWAY, BALTO. MD. 21213					APR 15 1969		Charles J. Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154
304 REV 7-64

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
05113																	
05105																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First Anna			Middle Louise			Last Maeser			2a. DATE OF DEATH 4 Month 15 Day 69 Year			2b. HOUR M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 11-21-89 88			6. AGE (In years last birthday) 80 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore County			Md.					
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2419 Pelham Ave.					
14. FATHER'S NAME First William			Middle Becker			Last Elizabeth			15. MOTHER'S MAIDEN NAME First Schumacher			Middle Last known					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Dorothy M. Schott - 2419 Pelham Avenue			Address					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the stomach metastases</u>																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fucus plugging of bronchi - pulmonary atelectasis</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or R.F.D. No			City or Town			County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Gunn Call, MD			22c. DATE SIGNED 4-16-69			22d. PHYSICIAN'S NAME (Type) Pathologist			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-19-69			23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland								
24. FUNERAL DIRECTOR John C. Miller Inc - 415 Belair Road - 21206			25a. REC'D BY REGISTRAR APR 22 1969			25b. REGISTRAR'S SIGNATURE Charles Judge											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05114

05106

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A.M.	
William		E.		Magill	April 6 1969		11:03	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		10-19-1887		81 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
New York		U.S.A.				Baltimore Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		St. Joseph Hospital		Retired				
13a USUA. RES DENCE (Where deceased lived, if institution Res dence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Maryland		Baltimore				YES		Woodhome Ave. #21234
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
George				Magill	Catherine			Young
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
Yes <input checked="" type="checkbox"/> (No <input type="checkbox"/>)		WW 1		216-05-3686		Katherine Magill Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary emphysema								
DUE TO, OR AS A CONSEQUENCE OF Congestive heart failure								
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 3-25, 1969, to 4-6, 1969, that (I) (we) last saw the deceased alive on 4-8-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE J. Banderas.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-6-69		
22d. PHYSICIAN'S NAME (Type) J. Banderas, M.D.				22e ADDRESS 7620 York Road, Towson, Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		4/9/69		Loudon Park		Baltimore, Maryland		
24 FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland				ADDRESS		25a REC'D BY REGISTRAR APR 8 1969		25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05115											
CERTIFICATE OF DEATH											
05107											
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
Carl			A.		Maneth				4 22 1969		
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7b. HOUR		
Male		Cau.		5-31-1907			61 YRS.		M		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
Kansas		U.S.A.		WIDOWED		DIVORCED		Baltimore			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Fullerton			4139 Oak Hill Ave.			Body & Fender			Garage		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.			Baltimore		Fullerton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4139 Oak Hill Avenue 21236		
14 FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Charles			Maneth		Augusta		Zimmer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address		
NO			212-01-3189			Mrs Lula E. Maneth			4139 Oak Hill Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1991 DUE TO, OR AS A CONSEQUENCE OF <u>undet.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bone fleeter sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF <u>undet.</u> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-19-64</u> , 19 <u>64</u> , to <u>4-22</u> , 19 <u>69</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>4-21</u> , 19 <u>69</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(determine)</u> view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
<u>John C. Hyle</u>								<input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-24-69</u>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
<u>JOHN C. HYLE</u>						<u>7527 Belair Rd</u>		<u>Baltimore 21236 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>			<u>11-25-1969</u>		<u>Lorraine Cemetery</u>			<u>Baltimore</u>		<u>Co. Md.</u>	
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Massahn Funeral Home 7401 Belair Road 21236</u>						<u>APR 25 1969</u>		<u>William J. Jones</u>			

05116

CERTIFICATE OF DEATH

05108

1 DECEASED NAME (Type or print)		First	Middle		Last	2a DATE OF DEATH		2b HOUR	
BLANCHE		McLANE		MANSON		04 Month 16 Day Year 69		11:00	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR	
FEMALE		CAU		1-30-12		57 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
NOVA SCOTIA		U.S.A.				BALTIMORE CO.		Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tnl give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
TOWSON, MD.		GTR. BALTO. MED. CENTER		HOUSEKEEPER + SERVANT					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MD.		A.A. Co.		Baltimore				145 Williams Dr.	
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
				McLANE				YANK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address	
No						THOMAS B. KLAKEING #13			
18 CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ne for (a), (b), and (c))		LIVER FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		DAYS	
174X		DUE TO, OR AS A CONSEQUENCE OF		METASTATIC CARCINOMA OF LIVER		SEVERAL MO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF		PRIMARY BREAST CANCER		6-7 YRS	
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-03, 19 69, to 4-16, 1969, that (I) (we) last saw the deceased alive on 4-16, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c. DATE SIGNED		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		4-16-69			
22d. PHYSICIAN'S NAME (Type)		RICHARD L. SMITH MD		22e ADDRESS		6701 NORTH CHARLES STREET			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
BURIAL		4-21-69		Hillcrest		Baltimore A.A. MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
John M. L. Loxton		Baltimore, Md.		APR 22 1969		[Signature]			

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VR 1515
30M REV 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05117		CERTIFICATE OF DEATH						05109	
1. DECEASED-NAME (Type or print)		First Annie		Middle M.		Last Marriott		2a. DATE OF DEATH April 13 1969	
3. SEX female		4. RACE white		5. DATE OF BIRTH 1892		6. AGE (In years last birthday) 76 YRS		2b. HOUR 12-AM	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore		Md.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) gardner		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY BALTO.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1803 Dover Street	
14. FATHER'S NAME First BASIL		Middle LAVEY		Last MARGARET		15. MOTHER'S MAIDEN NAME First MARGARET		Middle REDMOND	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 219-20-7787A		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>C.V.A.</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 16</u> , 19 <u>68</u> , to <u>4/13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dennis D. Agallianos</u>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED D. RECTR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/13/69</u>			
22d. PHYSICIAN'S NAME (Type) DENNIS D. AGALLIANOS		22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-16-69		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE CEMETERY		23d. LOCATION (City or Town) BANDELLSTOWN		(County) (State) MD.	
24. FUNERAL DIRECTOR WALTERS FUN'L HOME PRATT+STRIKER STS		ADDRESS		25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05118			05110		
1 DECEASED NAME (Type or print) John A. MASON			2a. DATE OF DEATH 4 Month 26 Day 69 Year		
3 SEX M			4 RACE NEGRO		5. DATE OF BIRTH 12/23/91
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH TOWSON			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 312 LENNOX AVE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CUSTODIAN
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN TOWSON	
14. FATHER'S NAME First John Middle MASON Last UNKNOWN		15 MOTHER'S MAIDEN NAME First UNKNOWN Middle UNKNOWN Last UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 214-20-5035		17 INFORMANT Address MARIE MASON-312 LENNOX AVE.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDIT.ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-20 , 19 68 , to 4-26 , 19 69 , that (I) (we) last saw the deceased alive on 4-26 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jerome Gaber DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4/28/69	
22d. PHYSICIAN'S NAME (Type) JEROME GABER				22e. ADDRESS 5706 BELLONA AV	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/1/69		23c. NAME OF CEMETERY OR CREMATORY Pleasant Rest	
24. FUNERAL DIRECTOR Wm. J. Chatman Jr.		ADDRESS 1701 Mt. Cyllod St. Balto, Md.		25a. REC'D BY REGISTRAR APR 29 1969	
				25b. REGISTRAR'S SIGNATURE William J. Chatman Jr.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

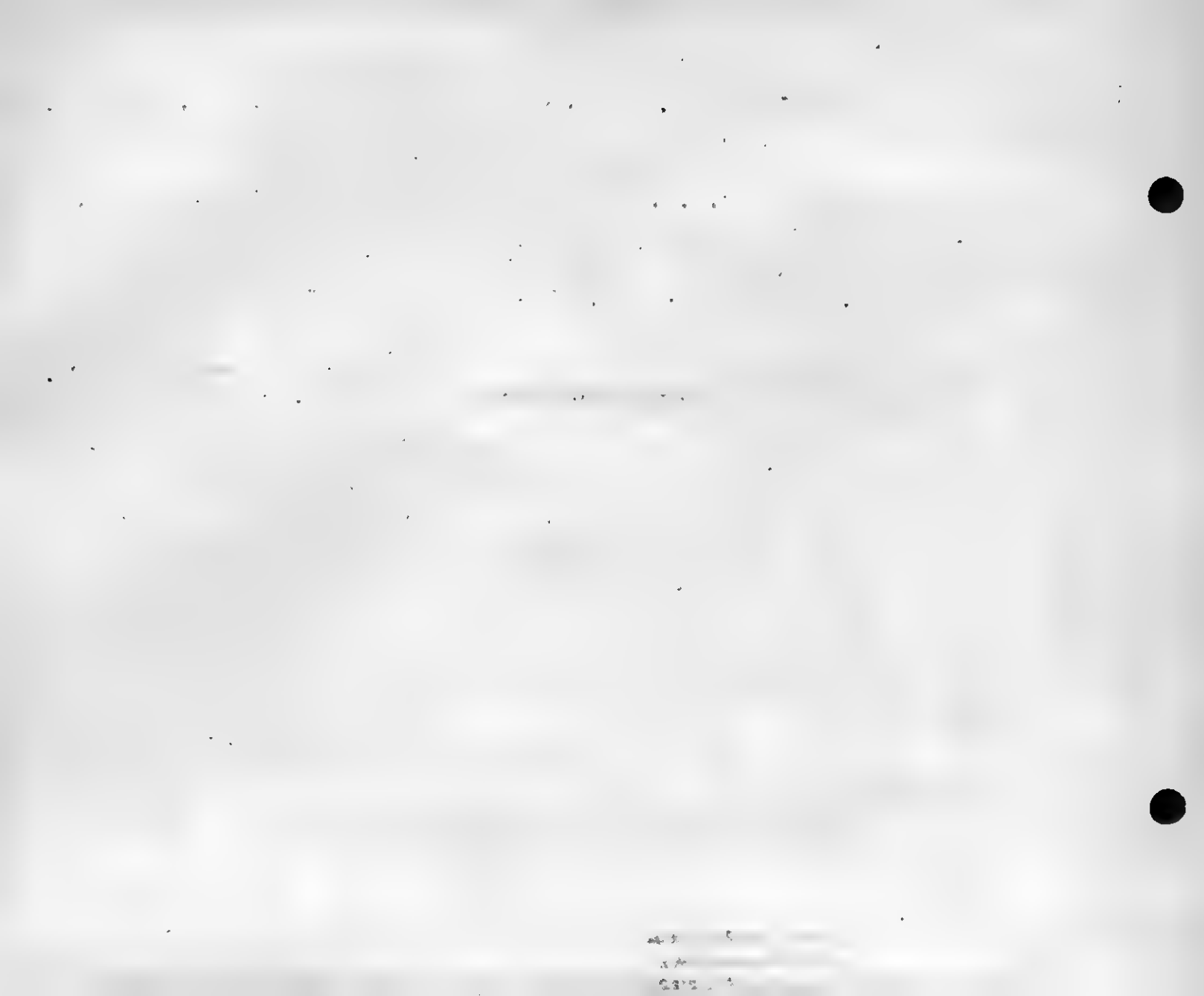
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

051119

05111

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Catherine A. Masters</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>15</i> Year <i>1969</i>		2b. HOUR <i>4:30</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>July 28, 1880</i>		6. AGE (In years last birthday) <i>88</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Cape Britton,</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Baltimore County,</i> Md.		
10. CITY OR TOWN OF DEATH <i>Canada Catonsville</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>29 Darrow Drive</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Cashier</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Catonsville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>29 Darrow Drive</i>	
14. FATHER'S NAME First Middle Last <i>-- Mombourquette</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>-- MacDougal</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO (If yes give year or dates of service) <i>077-20-9206</i>		17. INFORMANT <i>29 Darrow Drive - 21228. Mrs. Josephine I. McAllister</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive heart failure</i> stating the underlying cause last (c) <i>After CVD.</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>10 days</i> <i>20 years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Carcinoma, skin of forehead</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 21, 1964</i> , to <i>April 15, 1969</i> , that (I) (we) lost the deceased alive on <i>April 5, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Rebecca Gaffe</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>4/15/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Rebecca Gaffe</i>		22e. ADDRESS <i>5501 Forest Park Ave</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>April 17, 1969</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery - Baltimore, Md.</i>	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>3736 Edmondson Ave. Catonsville, Md. 21228</i>	25a. REC'D BY REGISTRAR <i>APR 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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05120

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

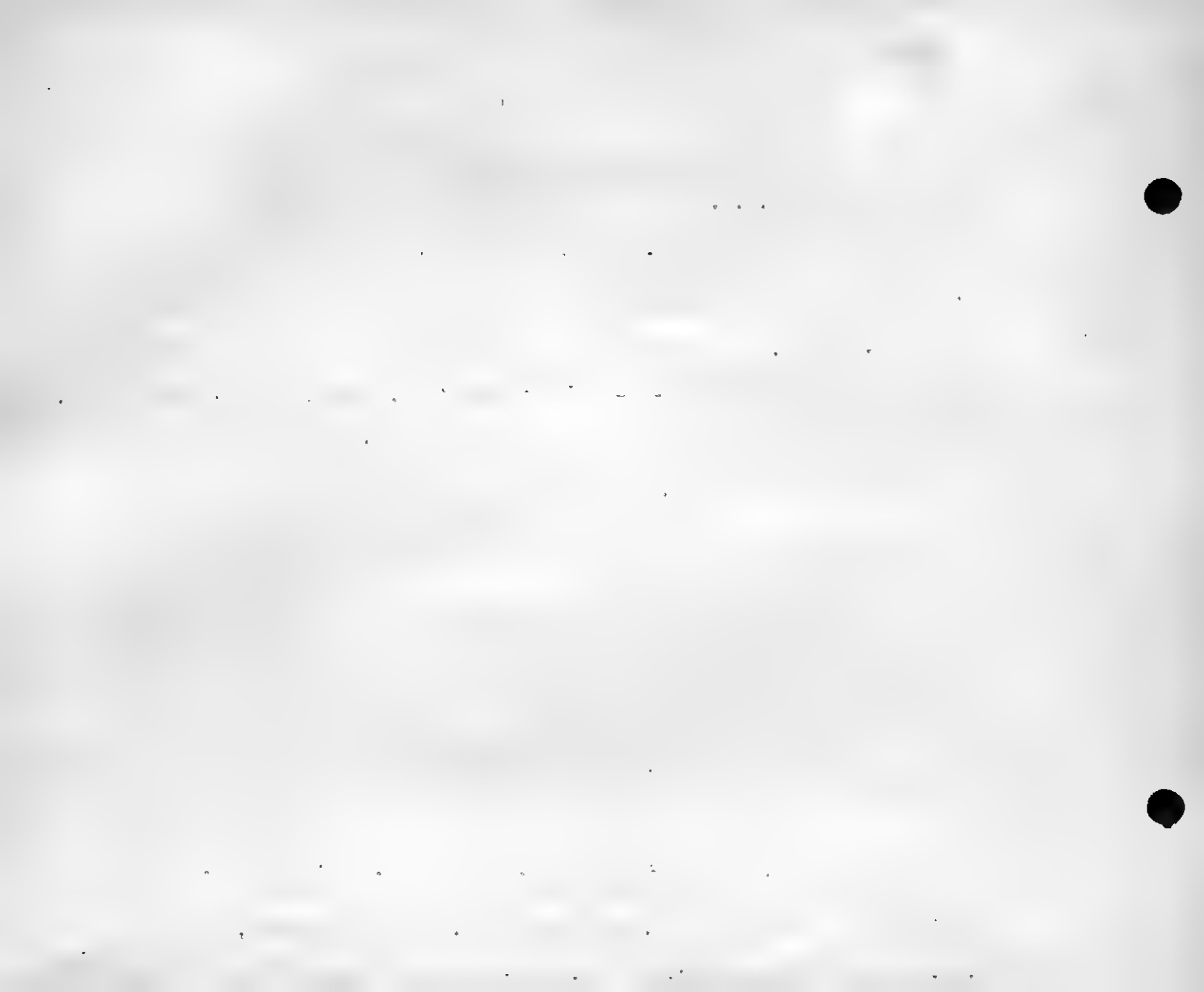
05112

1 DECEASED NAME (Type or Print) JOHN F. MATOSKA			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> APRIL 20 1969			2b HOUR 11:30			
3 SEX M	4 RACE W	5 DATE OF BIRTH 12/3/13	6 AGE (In years last birthday) 55 YRS	IF UNDER 1 YEAR MONTHS 0	DAYS 0	IF UNDER 24 HRS HOURS 0	MIN. 0	2c DATE PRONOUNCED DEAD Month 4 Day 21 Year 1969	2d HOUR 1230			
7a BIRTHPLACE (State or foreign country) MD.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTO.						
10 CITY OR TOWN OF DEATH DUNDALK			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 3459 YORKWAY			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BUS DRIVER			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD.			13b COUNTY BALTO		13c CITY OR TOWN DUNDALK		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 3459 YORKWAY			
14 FATHER'S NAME JOHN MATOSKA			First Middle Last			15 MOTHER'S MAIDEN NAME BARBARA CECK			First Middle Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b SOCIAL SECURITY NO 216-01-1332		17 INFORMANT MARIE MATOSKA			ADDRESS ABOVE				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HCUD DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. _____			City or Town _____		County _____ State _____	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE Theo C Patterson			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4/22/69			
EXAMINER'S NAME (Type) THEO C PATTERSON			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) BALTO. MD.						
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE 4/24/69		23c NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.			23d LOCATION (City or Town) (County) (State) BALTO. MD.					
24. FUNERAL DIRECTOR J.E. CONNELLY SONS						ADDRESS 300 MACE			25a REC'D BY REGISTRAR APR 24 1969			
						25b REGISTRAR'S SIGNATURE William Under						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05121 CERTIFICATE OF DEATH 05113									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
ANTHONY			C.		MAZUREK	4 Month 4 Day 69 year			5 20 a.m.
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		FEBRUARY 12, 1920		49 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE Co.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON			GREAT. BALT. MED. CEN.			AGENT		INSURANCE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Baltimore				1820 Putty Hill Road		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Marcel J. Mazurek			Martha -- Walinski						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)			WWII		212-01-7127 Marguerite H. Mazurek 1820 Putty Hill Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE CARDIAC FAILURE									
4101 DUE TO, OR AS A CONSEQUENCE OF (b) M. INFARCTION									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from MARCH 31, 1969, to APRIL 4, 1969, that (I) (we) last saw the deceased alive on APRIL 4, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M.N. AL-MUMAYEZ					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/5/69		
22d. PHYSICIAN'S NAME (Type) DR. M.N. AL-MUMAYEZ M.D.					22e. ADDRESS 6701 N. CHARLES ST. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-7-69		St. Stanislaus Cem.		Baltimore, Maryland			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. E. Johnson 8521 Loch Raven Blvd. 21204					DATE APR 7 1969		J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 15
30M REV 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05122

CERTIFICATE OF DEATH

05114

1 DECEASED NAME (Type or print) Gertrude Mooney			First Middle Last			2a. DATE OF DEATH Month Day Year April 5 69			2b. HOUR 6.30 PM		
3 SEX Female			4. RACE White			5. DATE OF BIRTH 12-25-1894			6 AGE (In years last birthday) 74 YRS.		
7a BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.		
10 CITY OR TOWN OF DEATH Towson			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore			13c CITY OR TOWN Towson			3d INSIDE CITY, MD. IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET AND NUMBER 16 Aigburth Rd., -21204			14 FATHER'S NAME First Middle Last James J. Mooney			15. MOTHER'S MAIDEN NAME First Middle Last Mary O'Leary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Mrs. Janet Galvin			Address 300 Cedarcroft Rd. 12		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive Heart Failure 492X DUE TO, OR AS A CONSEQUENCE OF (b) Cor Pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/31/1969 to 4/5/1969 , that (I) (we) last saw the deceased alive on 4/5/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gualberto Gokim Jr.			DEGREE M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 4-5-69		
22d. PHYSICIAN'S NAME (Type) Gualberto Gokim Jr. M.D.			22e. ADDRESS 7620 York Rd., Towson, Md. 21204								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/9/69			23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery			23d. LOCATION (City or Town) (County) (State) Balto. Md.		
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd. 21212			ADDRESS			25a. REC'D BY REGISTRAR DATE APR 7 1969			25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

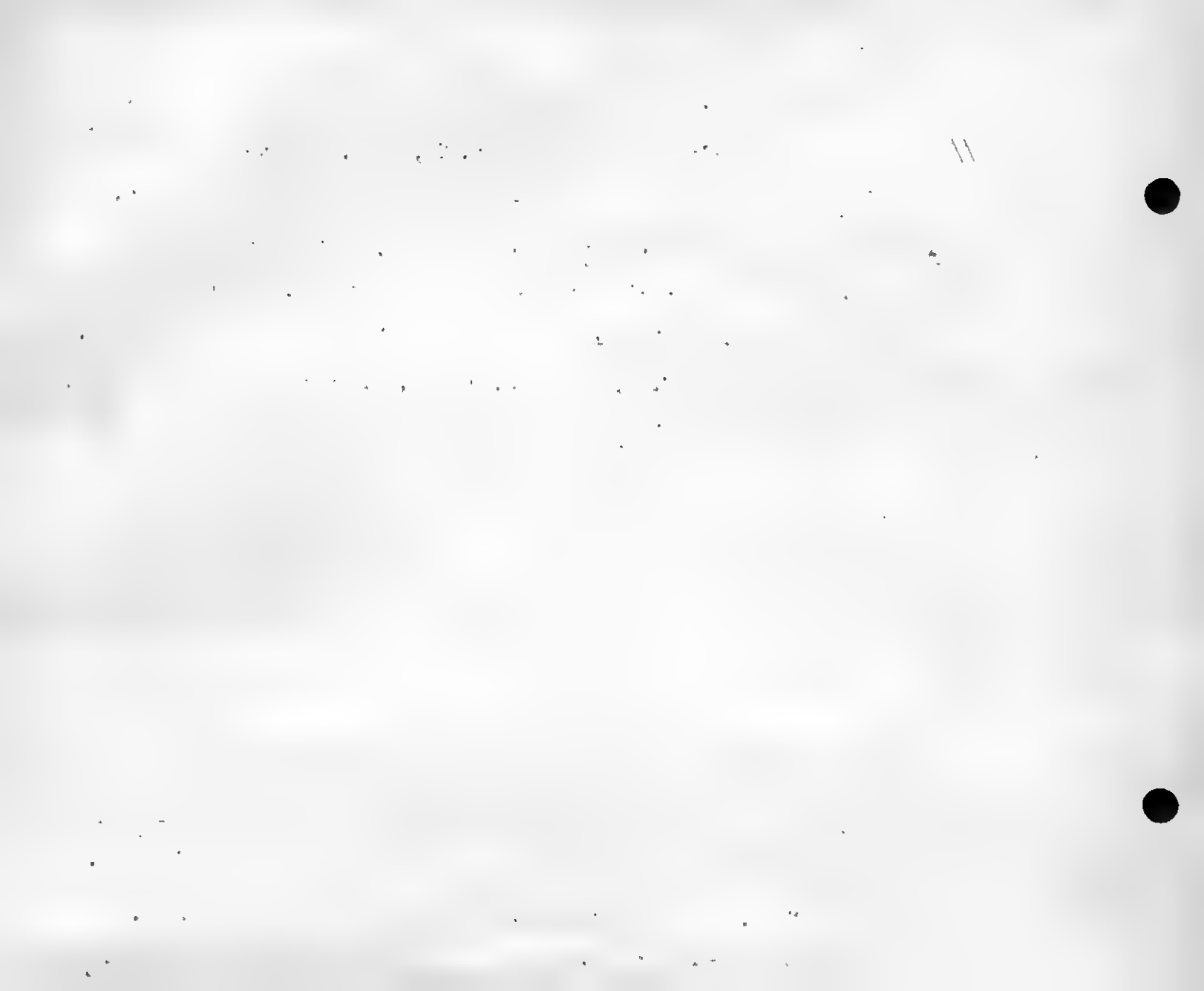
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05123

CERTIFICATE OF DEATH

05115

1. DECEASED NAME (Type or print) CLARENCE B. MILLER			2a. DATE OF DEATH Month April Day 5 Year 1969			2b. HOUR M							
3. SEX Female		4. RACE caucasian		5. DATE OF BIRTH Feb. 25, 1876.		6. AGE (In years last birthday) 93 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore, Md							
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1319 Highland Drive			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Engineer PRR			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		3a. INS. DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1319 Highland Drive					
14. FATHER'S NAME First William Middle E. Last Miller			15. MOTHER'S MAIDEN NAME First Sarepta Middle Gore Last Gore										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO A-123239		17. INFORMANT Mrs. Dorothy R. Capparelli			Address (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) viral gastroenteritis DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 4/3 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Dr. Gus Britsas						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/5/69					
22d. PHYSICIAN'S NAME (Type) Dr. Gus Britsas						22e. ADDRESS 6017 Alta Avenue, Balto, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/8/69.		23c. NAME OF CEMETERY OR CREMATORY Hereford Baptist Cemetery				23d. LOCATION (City or Town) (County) (State) Hereford, Md.					
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Balto, Md. - 14						25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

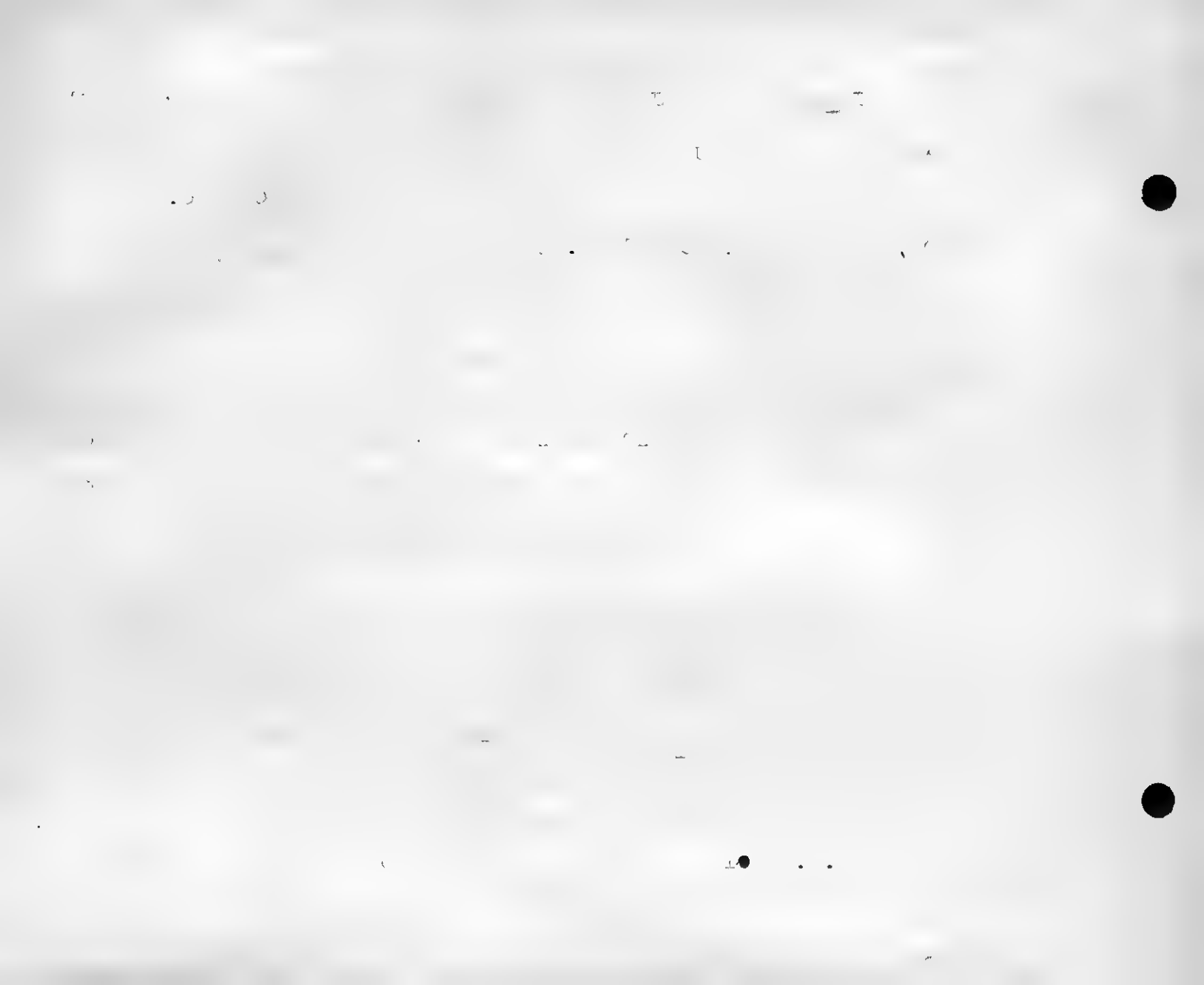
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
EMILY KNIGHT MILLER								Month Day Year	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		2c. DATE PRONOUNCED DEAD	
F		W		7-19-15		53 YRS		Month Day Year	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR	
MD		USA				BALTIMORE		11 30 P M	
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	
COCKEYSVILLE				250 ASHLAND AVE.				HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD				BALTO.		COCKEYSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER			
First Middle Last				First Middle Last		250 Ashland Ave.			
ROBERT HENRY RILEY				ANNIE (NINN) FOWLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT			
NO				NONE		MRS. SARAH BLIZZARD			
						ADDRESS 10 FAIRMOUNT RD. HAMPSHIRE, MD. 21074			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HYPERTENSIVE CEREBROVASCULAR DISEASE								5 YRS	
4. DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
BRONCHIAL ASTHMA									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				P.M. 19					
2d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, P.O. Box, or county)		4-24-69	
WILLIAM A. PINEBURY									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		4-28-69		BEL AIR MEMORIAL GARDENS		BEL AIR		MARYLAND	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
WM. COOK-BROOKS TOWSON, INC.				1050 YORK RD TOWSON, MD. 21204		APR 25 1969		J. J. JUDGE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) MILLER JAMES PERKINS					2a. DATE OF DEATH 04h 09 Year 69		2b. HOUR 12:40 AM		
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH APRIL 5, 1921		6. AGE (In years last birthday) 48 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE CO.			
10. CITY OR TOWN OF DEATH BOWSON, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GBMC 6701 N. CHARLES			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY FREIGHT	
13a. USUAL RESIDENCE (Where deceased lived; if institution, an Residence before admission) STATE MD.			13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 403 So. CALHOUN ST.		
14. FATHER'S NAME First Middle Last HERBERT MILLER			15. MOTHER'S MAIDEN NAME First Middle Last LENA EYRING						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES (If yes give war or dates of service) W.W.II			16b. SOCIAL SECURITY NO 217-03-2683		17. INFORMANT MARGARET MILLER		Address 403 So. CALHOUN ST.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE 16-21 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRAIN METASTASIS OF LUNG CANCER (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 16 MONTHS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-08 , 19 69 , to 4-09 , 19 69 , that (I) (we) last saw the deceased alive on 4-09-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE B.R. Choi M.D.					22c. DATE SIGNED 4-9-69				
22d. PHYSICIAN'S NAME (Type) B.R. CHOI					22e. ADDRESS 6701 NORTH CHARLES STREET				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE ARR. 12, 1969		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY		23d. LOCATION (City or Town) (County) (State) HOWARD COUNTY MD.			
24. FUNERAL DIRECTOR WALTERS FUN'L HOME PRATT+STRIKER STS.					25a. REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE W. Walters		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05126

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05118

1. DECEASED NAME (Type or print)				First Middle Last				2c. DATE OF DEATH				2b. HOUR	
Robert John Miller Sr.								April 12 1969				M	
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (In years last birthday)		7- UNDER YEAR		IF UNDER 24 HRS	
Male		White		Sept. 7 1914				51 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Balto. Md.		U.S.A.				Baltimore Md.							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Parkville				3043 Woodside Ave.				Meat Cutter				A&P	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. RESIDE CITY L.W. 157		13e. STREET AND NUMBER			
Maryland				Balto.				YES <input type="checkbox"/> NO <input type="checkbox"/>		3043 Woodside Ave.			
14 FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
Frederick H. C. Miller				Minnie Spielman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. (If give war or dates of service)		17. INFORMANT Address							
No				212-07-4754		Mrs. Ruth E. Miller 3043 Woodside Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>INANITION</u>												2 MONTHS	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost													
(b) <u>ABDOMINAL CARCINOMATOSIS</u>												5 MONTHS	
DUE TO, OR AS A CONSEQUENCE OF													
(c) <u>COLON CARCINOMA</u>												9-12 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
11-4-1968				COLON OBSTRUCTION				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 4, 1968</u> to <u>April 9, 1969</u> , that (I) (we) lost saw the deceased alive on <u>April 9, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Michael K. Finegan										April 13 1969			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS									
MICHAEL K. FINEGAN				111 W. Monument St. 21201									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				4-16-69		Parkwood Cem.				Balto. Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Jesse H. 7401 Belay Rd.								APR 16 1969		Richard J. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05127

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05119

1. DECEASED-NAME (Type or print) First Middle Last Rose Lee Miller			2a. DATE OF DEATH Month Day Year APRIL 25 1969		2b. HOUR 12:20 PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-20-20	
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (In years last birthday) 48 YRS.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Co. Md			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. County General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SECRETARY	
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.	
14. FATHER'S NAME First Middle Last SAMUEL KARFUNKEL		15. MOTHER'S MAIDEN NAME First Middle Last HELEN HECHT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address MR. SAMUEL S. MILLER, 6001 HIGHGATE DR. #15	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA LIVER METASTATIC DUE TO, OR AS A CONSEQUENCE OF PRIMARY SITE NOT DETERMINED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from APRIL 3, 1969 , to APRIL 25, 1969 , that (I) (we) last saw the deceased alive on APRIL 25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Fausto G. Aquino, Jr. DEGREE ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 4-25-69	
22d. PHYSICIAN'S NAME (Type) FAUSTO G. AQUINO, JR.				22e. ADDRESS BALTIMORE COUNTY GEN. HOSP.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE 4-27-69		23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH	
23d. BURIAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		23e. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		23f. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25a. REC'D BY REGISTRAR APR 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

05128

CERTIFICATE OF DEATH

05120

1. DECEASED NAME (Type or print) WILLIAM H. MILLER			2a. DATE OF DEATH Month APR. Day 11 Year 1969			2b. HOUR M	
3. SEX M		4. RACE W		5. DATE OF BIRTH NOV. 18, 1919		6. AGE (in years lost birthday) 49 YRS	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO.	
10. CITY OR TOWN OF DEATH ESSEX		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) SEDEWATER TERRACE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER SEDEWATER TERRACE		14. FATHER'S NAME First WM. Middle H. Last MILLER SR.		15. MOTHER'S MAIDEN NAME First EVA Middle KERNER Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) YES WW II		16b. SOCIAL SECURITY NO. 215-16-7678		17. INFORMANT LOIS MILLER		Address 6 BOVE	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/10 , 19 66 , to 4/11 , 19 69 that (I) (we) last saw the deceased alive on 4/14 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. Lewis Kolodny		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/14/69	
22d. PHYSICIAN'S NAME (Type) A. Lewis Kolodny, M.D.		22e. ADDRESS 1825 Eastern Blvd - 21221					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/14/69		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City or Town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR J.B. CONNELLY SONS		ADDRESS 300 MACE		25a. REC'D BY REGISTRAR APR 16 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

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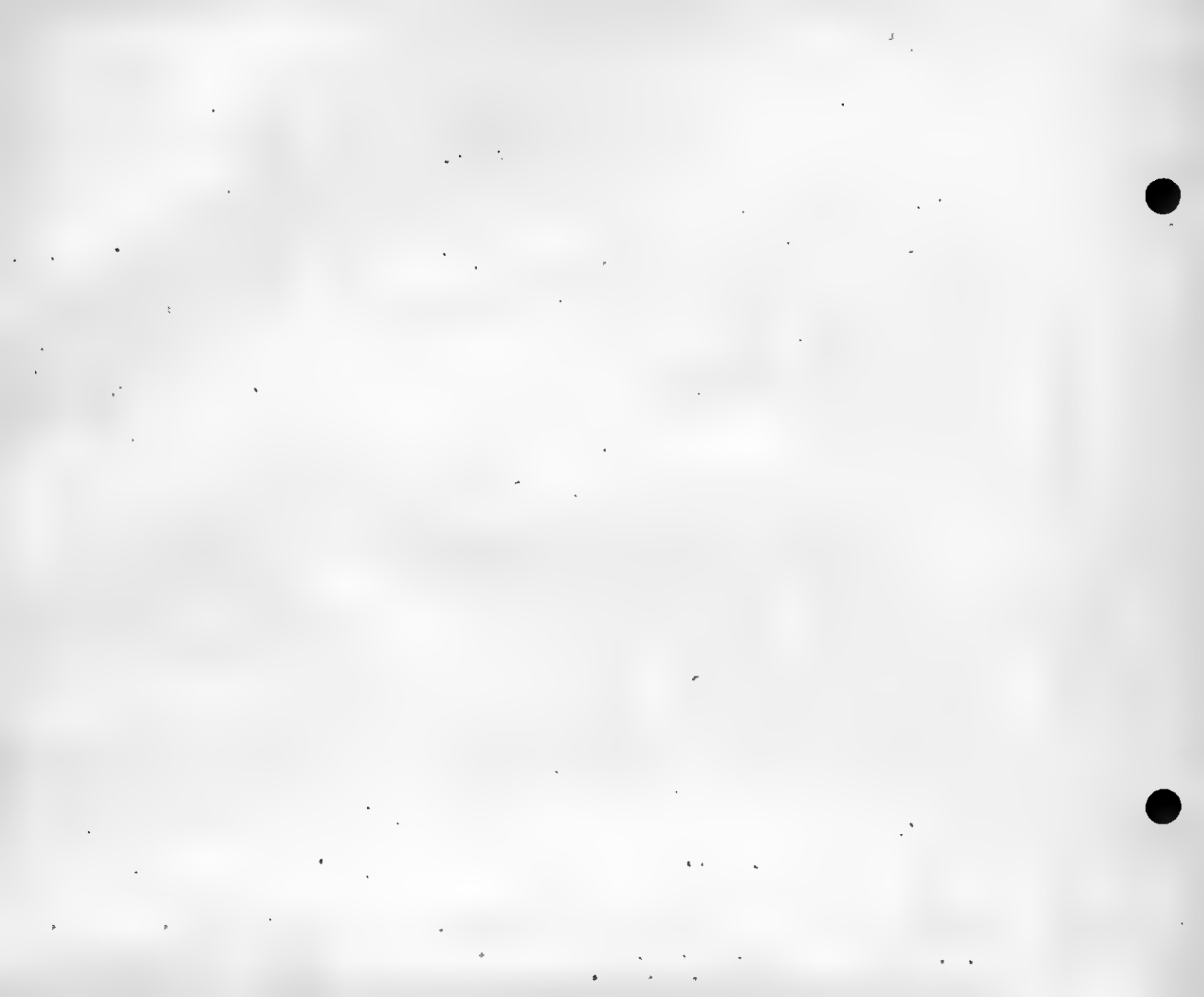
05129

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05121

1. DECEASED-NAME (Type or print) Laura E Monks			2a. DATE OF DEATH Month 4 Day 7 Year 69			2b. HOUR 7:30 PM								
3 SEX Female		4 RACE White		5. DATE OF BIRTH 10-15-88		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS 5 DAYS 16		F UNDER 24 HRS. HOURS MIN				
7a. BIRTHPLACE (State or foreign country) GOLEN ARM. Md			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE Md.					
10. CITY OR TOWN OF DEATH TOWSON Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Towson Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY DIVID HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b. COUNTY BALTO			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 251-A Rodgers Forge Rd.		
14. FATHER'S NAME First BENJAMIN Middle SNYDER Last SNYDER			15. MOTHER'S MAIDEN NAME First ELIZABETH Middle WIRSHING Last WIRSHING			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 218-54-0941			17. INFORMANT Address MISS R. IRMA MONKS (SAME)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 47 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS 3 YEARS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from JAN. 1968 , to APRIL 1969 , that (I) (we) last saw the deceased alive on MARCH 31, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Arthur Karfegin MD						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4/22/69					
22d. PHYSICIAN'S NAME (Type) ARTHUR KARFEGIN MD						22e. ADDRESS 1532 HAVENWOOD RD								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 4, 1969			23c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran			23d. LOCATION (City or Town) (County) (State) Grindon Lane, Md.					
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.						25a. REC'D BY REGISTRAR DATE APR 2 1969			25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 13 Film G412 4/30/69 kk									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Lou Ella Moser						April 14, 1969			8:30 a. M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
female		white		Oct. 3, 1891		77 YRS.		MONTHS DAYS HOURS M N	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Va.			U. S.				Baltimore Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Catonsville			SPRING GROVE STATE HOSP.			housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution, give street address)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
MO. Va.			Baltimore		Chilhowie		YES <input type="checkbox"/> NO <input type="checkbox"/>		Route #2 Masonic Home / Cockeysville
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Thomas Widner			Belle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
			226-48-6924A		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Right-sided pneumonia									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) Pleural effusion									
DUE TO, OR AS A CONSEQUENCE OF									
Arteriosclerotic cardiovascular disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION			
						Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from Oct. 3, 1968, to April 14, 1969, that (X) (we) last saw the deceased alive on April 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Diomidis Pirovolidis, M.D.								22c. DATE SIGNED 4-14-69	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
			SPRING GROVE STATE HOSPITAL			Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
			Apr. 17, 1969		Mt. View		R.F.D. Marion, Smyth, Va.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Jimmy Smith			APR 22 1969			[Signature]			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05131

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05123

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR
MARK V MOUDRY						April 28 1969			4:10 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD	2d HOUR
MALE	W	5-3-1953	15 YRS					April 28 1969	4:10 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Baltimore			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Glenarm			Not a CLIF RL			Student			School
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER			
Md			BALTO	Glenarm		8709 Littlewood Rd			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Richard F Moudry						Julie M DOUSA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS
No						Father			Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Contusions of</u> DUE TO, OR AS A CONSEQUENCE OF <u>Skull-Fracture of Neck</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Sudden</u> (b) <u>and partial to complete Strangulation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>and partial to complete Strangulation</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year April 28 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Thrown clear of Car into Streetcar				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) Street		21f LOCATION Street or R.F.D. No. City or Town State Not a CLIF Rd - Glenarm Md				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b DATE SIGNED 4/28/69
CHARLES F. O'DONNELL									
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town)		(County)	(State)
Burial		5-1-1969		PARKWOOD		BALTO		MD	
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
CHAS. T. EVANS & Son				8802 Ha Ford RL		DATE APR 30 1969		Glenarm, Md	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1

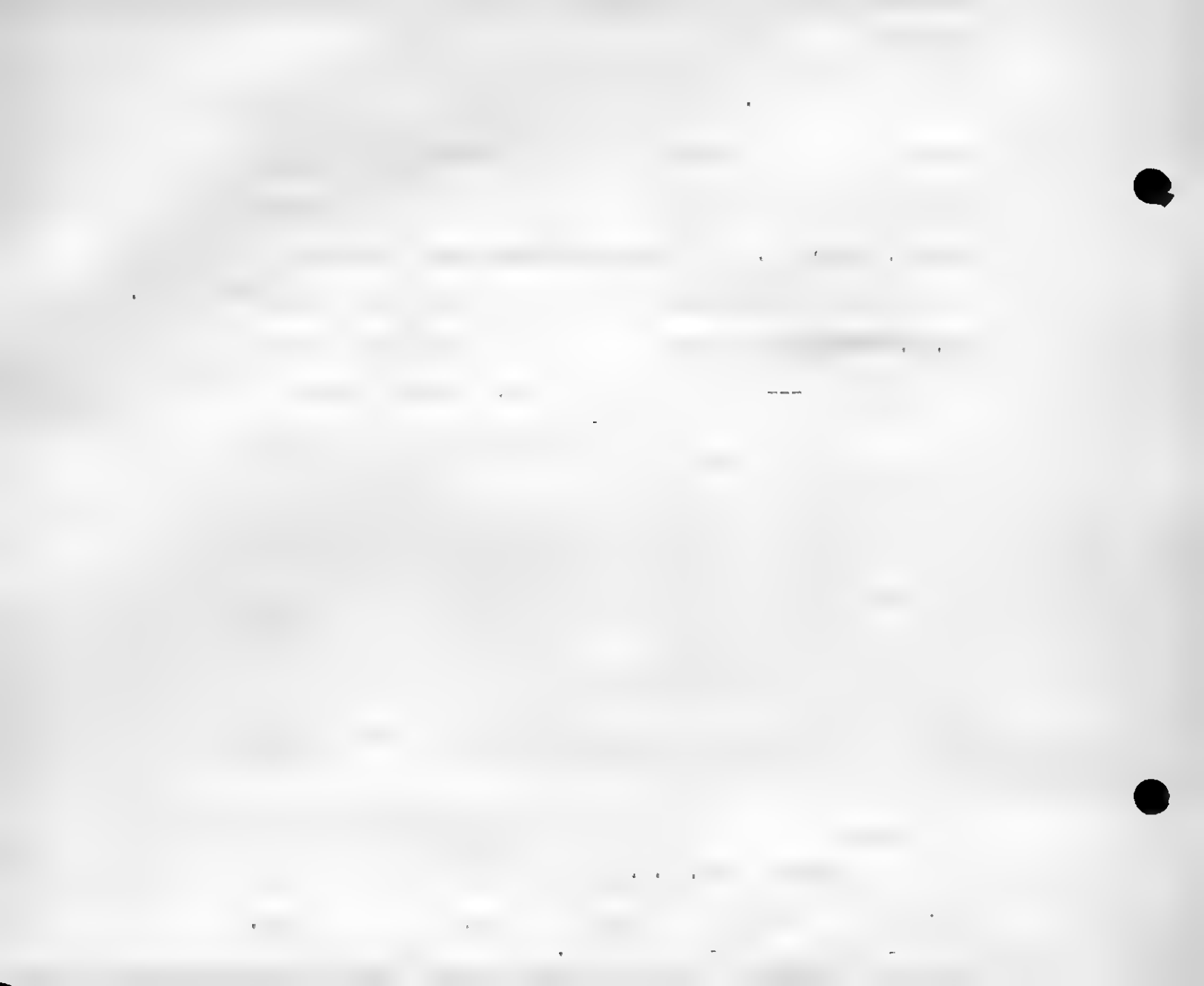
05132 DIVISION OF VI
Item 23 Film 16 9/11/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05124

1. DECEASED NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
ANNA B. MOULTON				April 29th, 1969		4:39 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
Female		White		December 8, 1885		83 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		USA				Baltimore Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Anneslie, Balto. Co.		Armecost Nursing Home		Homemaker			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY (If YES) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Baltimore				13e. STREET AND NUMBER	
						516 Anneslie Rd.	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
Morris Brown		Margaret Crowley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
no				Mrs. Gertrude Quigley 4206 Roland Ave			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621 Carcinoma Left Lung						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from Jan 4, 1969, to April 29, 1969, that (I) (we) last saw the deceased alive on April 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Lawrence Post, M.D. DEGREE				22c. DATE SIGNED 4/30/69			
22d. PHYSICIAN'S NAME (Type) Lawrence Post, M.D.				22e. ADDRESS 6805 York Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/30/69		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City or Town) (County) (State) Balto.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd. 21212 ADDRESS				25a. REC'D BY REGISTRAR MAY 6 1969		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05133									
CERTIFICATE OF DEATH									
05125									
1. DECEASED NAME (Type or print) First Middle Last Amy Gertrude Munroe					2a. DATE OF DEATH Month Day Year 4 21 1969		2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 18, 1875		6. AGE (in years last birthday) 93 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Anneslie			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armecost Nur. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER 706 Kingston Rd.		
14. FATHER'S NAME First Middle Last George T Parrish			15. MOTHER'S MAIDEN NAME First Middle Last Sarah E. Byers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 216 46 7250		17. INFORMANT Address Mrs Ernest P. Benseler 706 Kingston Rd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Supremacy of Age</u> 4 DUE TO, OR AS A CONSEQUENCE OF <u>Senile and Arteriosclerosis</u> (b) <u>Senile and Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1960</u> to <u>4-21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-21</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thomas G. Abbott</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <u>Thomas G. Abbott</u>					22e. ADDRESS <u>4509 S. Baltimore Ave</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/24/69		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City or Town) (County) (State) Woodlawn Balto. Md.			
24. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.					25a. RECD BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE <u>Thomas G. Abbott</u>		

FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05134										05126													
1. DECEASED NAME (Type or Print) First Middle Last CHARLES EDWARD MURPHY										2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year 4 30 1969													
3 SEX Male		4. RACE White		5. DATE OF BIRTH Jan 20 1951		6 AGE (In years last birthday) 18 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year April 30 1969											
7a. BIRTHPLACE (State or foreign country) Md				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Balto.											
10. CITY OR TOWN OF DEATH Parkville				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garage 2713 Alden Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Driver				12b. KIND OF BUSINESS OR INDUSTRY A J Auto P.											
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE Md.				13b. COUNTY Balto.				13c. CITY OR TOWN Parkville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2713 Alden Rd.									
14. FATHER'S NAME First Middle Last CHARLES H. MURPHY										15. MOTHER'S MAIDEN NAME First Middle Last CHARLOTTE CLARK													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 216-56-4685				17. INFORMANT ADDRESS Family records															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide intoxication 782X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month Day Year 29- 4 30 1969 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Unknown															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home farm, street, factory office building, etc.) Garage				21f. LOCATION Street or R.F.D. No. City or Town County State 2713 Alden Rd. Parkville Balto. Md.															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> James F. Wilson ACTUAL SIGNATURE M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D.																							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				23b. DATE 5/3/69		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley				23d. LOCATION (City or Town) (County) (State) Balto 60 Md.													
24. FUNERAL DIRECTOR ADDRESS C.F. EVANS & SON 8802 Harford road										25a. REC'D BY REGISTRAR MAY 1 1969				25b. REGISTRAR'S SIGNATURE Charles Judge									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in space in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05135 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05127					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED-NAME (Type or Print)			First MARGARET		Middle ELIZABETH		Last MURPHY		2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <input type="checkbox"/> April 18, 1969			2b HOUR :20A			
3 SEX Female		4 RACE White		5 DATE OF BIRTH May 16, 1910		6 AGE (in years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month April Day 18, Year 19 69		2d HOUR 7:20A	
7a BIRTHPLACE (State or foreign country)			Maryland			7b CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Ellicott City				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 26 Westchester Avenue				12a USUA. OCCUPATION (Kind of work done during most of work ng life, even if retired) Clerk retail store Bobs 5 & 10 cent				12b KIND OF BUSINESS OR INDUSTRY Store			
13a USUA. RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland				13b COUNTY Baltimore				13c CITY OR TOWN Ellicott City		13d INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 26 Westchester Avenue			
14. FATHER'S NAME First Middle Last Joseph Oliver Murphy					15. MOTHER'S MAIDEN NAME First Middle Last Mary Lingenfelter										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				(If yes give war or dates of service)				16b SOCIAL SECURITY NO 218-12-3285		17. INFORMANT Ellicott City, Address Md. 21043 Miss Lucy E. Murphy 26 Westchester Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROX MATE INT. RVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				19c. AUTOPSY (Partial) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy (Partial) Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Ronald N. Kornblum</u>				EXAMINER'S NAME (Type) Ronald N. Kornblum, MD.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4/21/1969				23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery							
24. FUNERAL DIRECTOR Eastern Funeral Home				ADDRESS Catonsville, Md.				25a. REC'D BY REGISTRAR APR 22 1969							
								25b. REGISTRAR'S SIGNATURE Charles Judge							
23d. LOCATION (City or Town) Ellicott City, Md.				(County) (State)											

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05136

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05128

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <input type="checkbox"/>		Month Day Year		2b. HOUR	
GLENN						MURRAY, JR.				19		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		Month Day Year		2d. HOUR	
male	white	July 4, 1924		44 YRS.				April		Day 29, Year 19 69		9:45 P. M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Pennsylvania		U. S. A.				Baltimore						Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY							
Edgemere		2326 Lincoln Avenue		Parts Clerk - Bethlehem Steel Co.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Baltimore		Edgemere				2326 Lincoln Avenue					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle	
Glenn						Murray		Myrtle				McGeary	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		ADDRESS					
Yes		WWII		390-26-8577		Mrs. Catherine . . Murray, 2326 Lincoln Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease													
4124 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				M.D.				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				Werner U. Spitz, M.D.				4/29/69					
ADDRESS (Street, city, town, or county)													
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY					
Burial				5/2/69				Oak Lawn Cemetery					
24. FUNERAL DIRECTOR				ADDRESS				25a. RECD BY REGISTRAR					
John J. Duda, 7922 Wise Ave. Dundalk, Md.								25b. REGISTRAR'S SIGNATURE:					
								DATE MAY 2 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05137 Item 8 Film 412 5/6/69 kk CERTIFICATE OF DEATH 05120									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
CATHERINE W. NAYLOR						4 Month 29 Year 69		8:56 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
FEMALE		CAUCASIAN		5-1-98		70 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Laurel Md.		USA				BALTIMORE		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		GREAT. BALT. MED CENT		housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Balto.		Reisterstown				Westminster Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Abraham Waterz			Elizabeth Strett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		213-36-1283		Mrs. Margaret W. Licht		Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST									
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION									
DUE TO, OR AS A CONSEQUENCE OF (c) HEART FAILURE									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> , 19 <u>69</u> , to <u>4-29</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4-29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (do) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED	
								4-29-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Helen C. Neuser M.D.				6701 N CHARLES ST					
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		May 2, 1969		Baltimore National		Baltimore, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J.F. Eline & Sons				Reisterstown, Md.		MAY 2 1969		Charles J. Jager	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

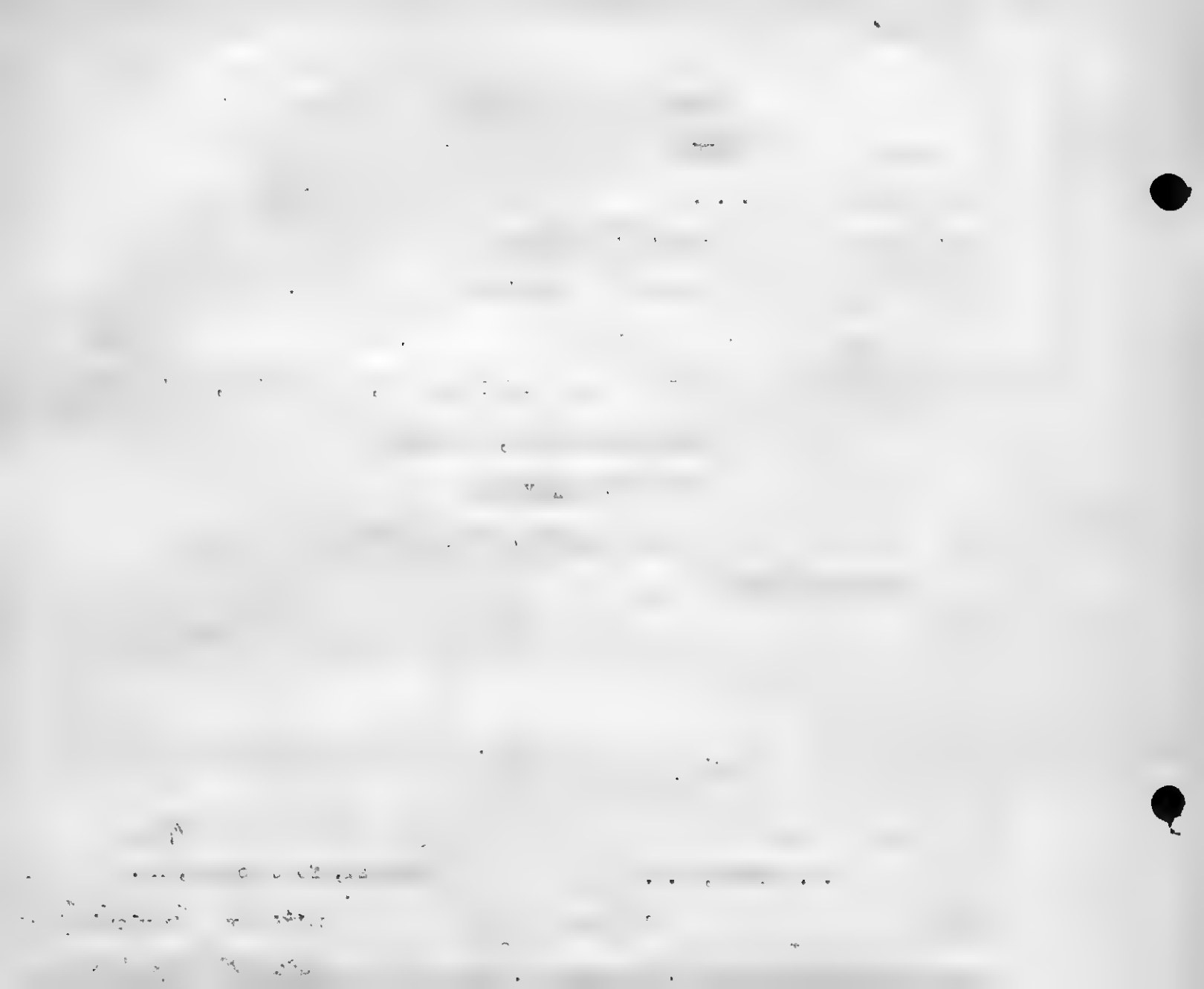
05133
Item 23 Film 411 4/14/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05130

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last GUY HENRY NAYLOR			2a. DATE OF DEATH Month Day Year APRIL 7 1969			2b. HOUR 6:30 M			
3. SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 9/15/92		6 AGE (In years, month, day) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE			
10 CITY OR TOWN OF DEATH FORT HOWARD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution) Res. dence before death (If not in Baltimore, give street address) MARYLAND		13b COUNTY CARROLL		13c CITY OR TOWN HAMPSTEAD		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Rt. 2	
14 FATHER'S NAME First Middle Last HARRY --- NAYLOR			15. MOTHER'S MAIDEN NAME First Middle Last SUE BLACK						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES		16b SOCIAL SECURITY NO WW-1 217 30 2948		17 INFORMANT Address CLINICAL RCDS, VA HOSPITAL, FORT HOWARD MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		State	
22a. I certify that (X) (this hospital) attended the deceased from Mar. 6 , 19 69 , to April 7 , 19 69 , that (X) (we) last saw the deceased alive on April 7 , 1969, and that in (NY) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.									
22b. SIGNATURE J. D. Talbert, M.D.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/7/69			
22d. PHYSICIAN'S NAME (Type) J. D. TALBERT, M.D.				22e. ADDRESS VA Hospital, Fort Howard, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 9, 1969		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR Joseph N. Zannino				ADDRESS Md 21224		25a. REC'D BY REGISTRAR APR 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	
ZANNINO FUNERAL HOME 257 S. Conkling St. Balto									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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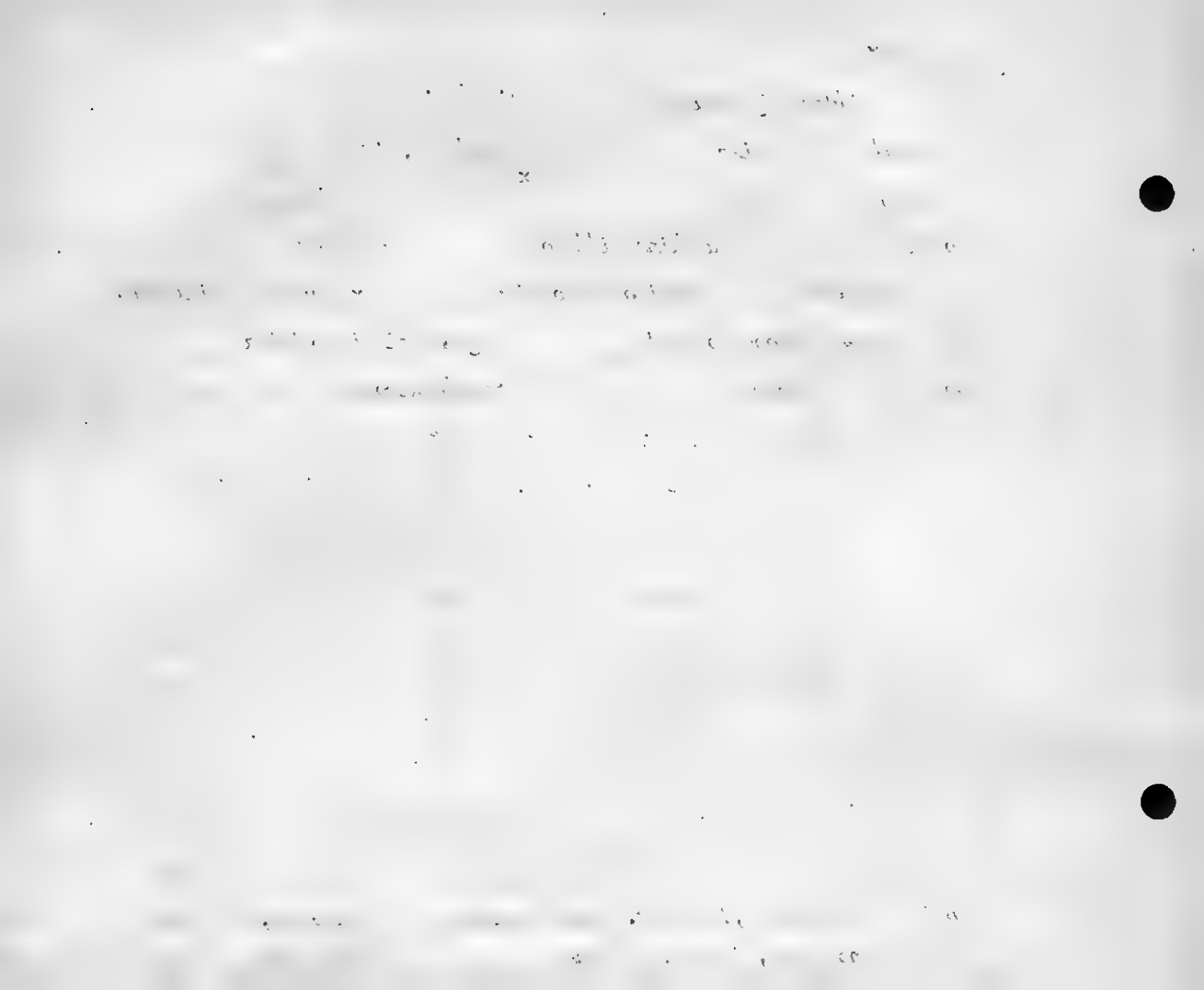
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05139

05131

1. DECEASED-NAME (Type or print) <i>Mildred Gertrude</i>		First Middle Last <i>NELSON</i>		2a. DATE OF DEATH <i>4</i> Month <i>12</i> Day Year <i>69</i>		2b. HOUR <i>7 P</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>July 15, 1899</i>		6. AGE (In years lost birthday) <i>69</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.	
10. CITY OR TOWN OF DEATH <i>Monkton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hutchins Mill Road</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Monkton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>Hutchins Mill Road</i>							
14. FATHER'S NAME First Middle Last <i>James Ellwood Fossett</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Emma Griffin Gettier</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Family records</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 immediate</i> <i>years</i>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>							
19a. DATE OF OPERATION <i>none</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>none</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i>none</i>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>none</i>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) <i>none</i>		21f. LOCATION Street or R.F.D. No. City or Town County State <i>none</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/14</i> , 19 <i>59</i> , to <i>4/12</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/19</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James F. White Jr. M.D.</i> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/12/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>James F. White Jr. M.D.</i>				22e. ADDRESS <i>Jarrettsville, Md 21334</i>			
23a. BURIAL, CREMATION, or other disposition <i>Burial</i>		23b. DATE <i>April 15, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Monkton, Maryland</i>	
24. FUNERAL DIRECTOR <i>John Buras' Sons, Towson, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>APR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

05132

Item 21 Film 412 5/8/69 kk

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 05140 MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN lb <u>3 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>		d. STREET ADDRESS <u>Balto. City Hospital</u>	
3. NAME OF DECEASED (Type or print) <u>Steve</u> First <u>Nickoless</u> Middle <u>Nickoless</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1969</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-28-1888</u>
9. AGE (n years lost birthday) <u>80</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State or foreign country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nickoless, Joe</u>		14. MOTHER'S M maiden NAME <u>Mary?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC DISEASE - CIRCULATORY</u> DUE TO <u>DISEASE & PRECIPITATING CAUSE -</u> (b) <u>ARTERIO-SCLEROTIC</u> DUE TO <u>PERIPHERAL CIRCULATORY COLLAPSE</u> (c) <u>PERIPHERAL CIRCULATORY COLLAPSE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour ' a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> , 19 <u>66</u> , to <u>4/17</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/17</u> , 19 <u>69</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/30/69</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>		22d. ADDRESS <u>6800 E. MONTGOMERY AVE. BALTO. 28, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>May 1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Maryland</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Hubbard Funeral Home-4107 Wilkins Ave. Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 5 1969</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05141

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05133

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR	
ANN M. Nickolson					APR 16 1969					4:45 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		
Female	White	Nov. 4, 1899		69 YRS	MONTHS DAYS		HOURS MIN		APR 16 1969		
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md.		U.S.A.				Baltimore Md					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Owings Mills				WARDS Chapel Rd.				Housewife		Home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.				Baltimore		Owings Mills				WARDS Chapel Road	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
Joshua L. Green				MARY - Herbert							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				—		MRS. HAROLD GRIMES		Owings Mills, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Disease										2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive C.V. Disease										18 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes										18 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
none								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
none				19 P.M.							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b DATE SIGNED			
D. D. CAPLES				M.D.				4-18-69			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER							
D. D. CAPLES, M.D.				6 Haverhill Rd. Randallstown, Md.							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		4-19-69		Mt. Olive Cemetery		Randallstown				Md.	
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Harry W. Haight				Lykeville, Md.				APR 22 1969		H. W. Haight	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05142

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05134

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
Anna		Emma	Norwitz		April Month 12 Day 1989 Year		555p.M				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR MONTHS		8 UNDER 24 HRS. HOURS MIN	
Female		Caucasian				73 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore County Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Randallstown		Balto. Co. Gen. Hosp.		HOUSEWIFE		AT HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.				Baltimore				7018 Park Hgts. Ave.			
14 FATHER'S NAME		First	Middle	Last	5. MOTHER'S MAIDEN NAME		First	Middle	Last		
Morris				Satsky	Miriam				XXXXXXXX		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
BT		215-32-9184		MR. GERSON NORWITZ		2024 COLEBROOK DR.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										A. APPROX. MORTALITY INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) <u>Acute MI</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Acute MI</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>4-12</u> , 19 <u>69</u> , to <u>4-12</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		G. NEARFON MD			DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-12-69</u>		
22d. PHYSICIAN'S NAME (Type)		G. NEARFON			22e. ADDRESS		BALTO. CO. GEN. HOSP.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		4-14-69		BNAI ISRAEL		BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR						ADDRESS		25a. REGISTERED REGISTRAR			
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD								APR 15 1969			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

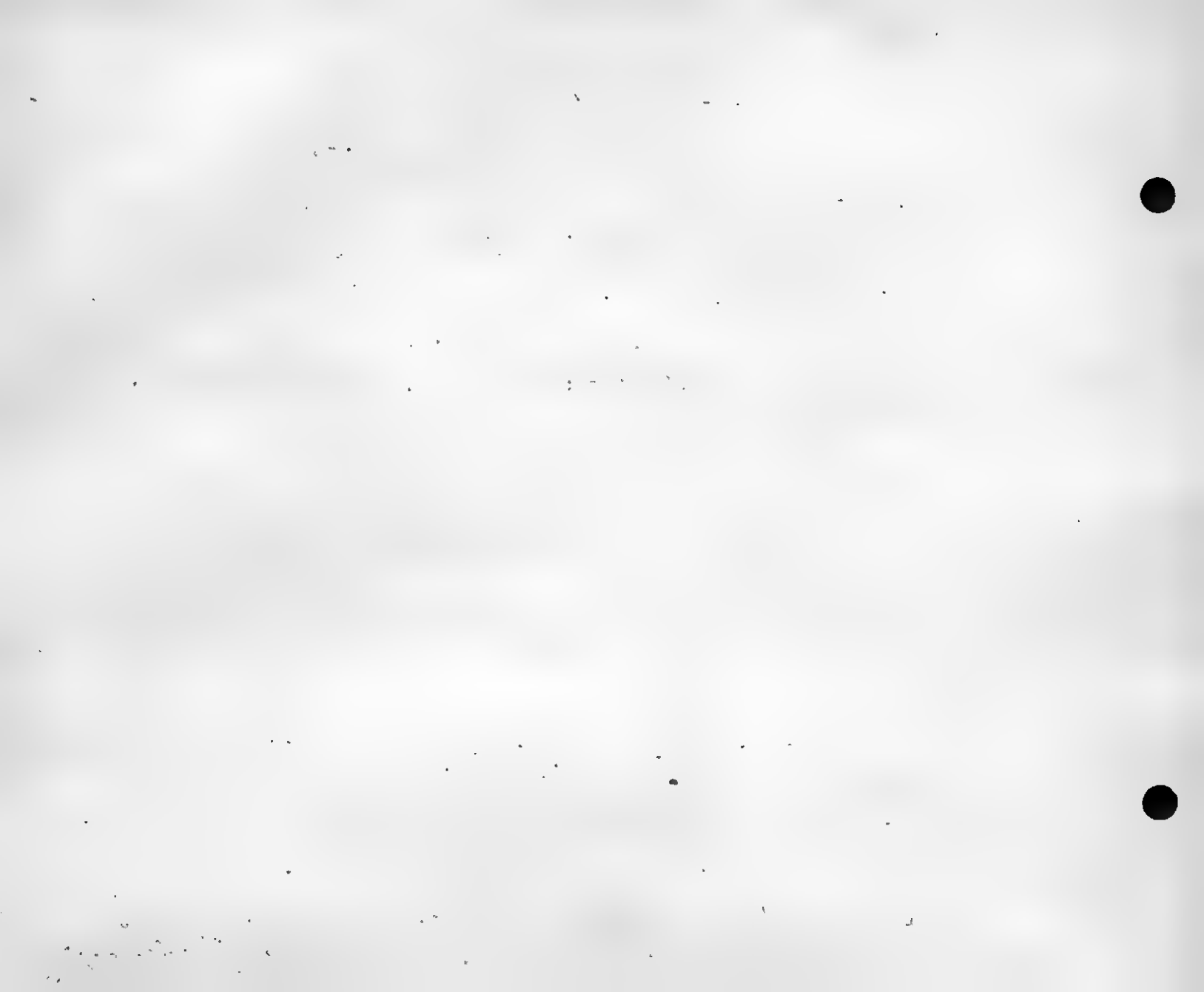
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
FRANCIS J NOWLAND						4 Month 28 Day 69 Year			4P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE		CAUCASIAN		10-14-24		44 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				BALTIMORE Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE, MD			GREAT. BALT. MED. CENT			Truck Driver			Balt. City
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			13		Baltimore			1207 W. Cross St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William J. Nowland			Clara Nelson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
					Mrs. Clara Nowland above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CA OF LUNG WITH METASTASIS									
1621 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-21, 19 69, to 4-28, 19 69, that (we) last saw the deceased alive on 4-28, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (diagnose) view the body after death.									
22b. SIGNATURE BIK. Choi M.D. DEGREE					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 42-8-69		
22d. PHYSICIAN'S NAME (Type) BIK CHOI, M.D.					22e. ADDRESS 6701 N CHARLES, ST.				
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/1/69		Woodlawn Cem.		Woodlawn Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
John J. Conner Inc.					APR 30 1969		[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05144		CERTIFICATE OF DEATH						05136		
1. DECEASED-NAME (Type or print) ROSE ELLEN O'DONNELL			First Middle Last			2a. DATE OF DEATH 4 Month 14 Day 69 Year		2b. HOUR 7:45 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12-11-1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) ALLENTOWN, PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MICHIGAN Baltimore Md.				
10. CITY OR TOWN OF DEATH TOULSON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DIXANEY TOWSON NURSING HOME - WEST ROAD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN 402 OVERBROOK ROAD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 21212		
14. FATHER'S NAME DENNIS			First Middle Last			15. MOTHER'S MAIDEN NAME DUGEN GILLISPIE, ANNIE DUGEN			First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 162 03 5767		17. INFORMANT Thomas J. O'Donnell Stevenson, Md		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF Carcinoma Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from July 10, 1968 , to April 17, 1969 , that (I) (we) saw the deceased alive on 4/17 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.										
22b. SIGNATURE Laurence C. Post M.D.		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/15/69				
22d. PHYSICIAN'S NAME (Type) Laurence C. Post		22e. ADDRESS 6805 York Rd.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/16/69		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Balto Md				
24. FUNERAL DIRECTOR Mitchell Wiedefeld		ADDRESS Home 6500 York Rd.		25a. REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

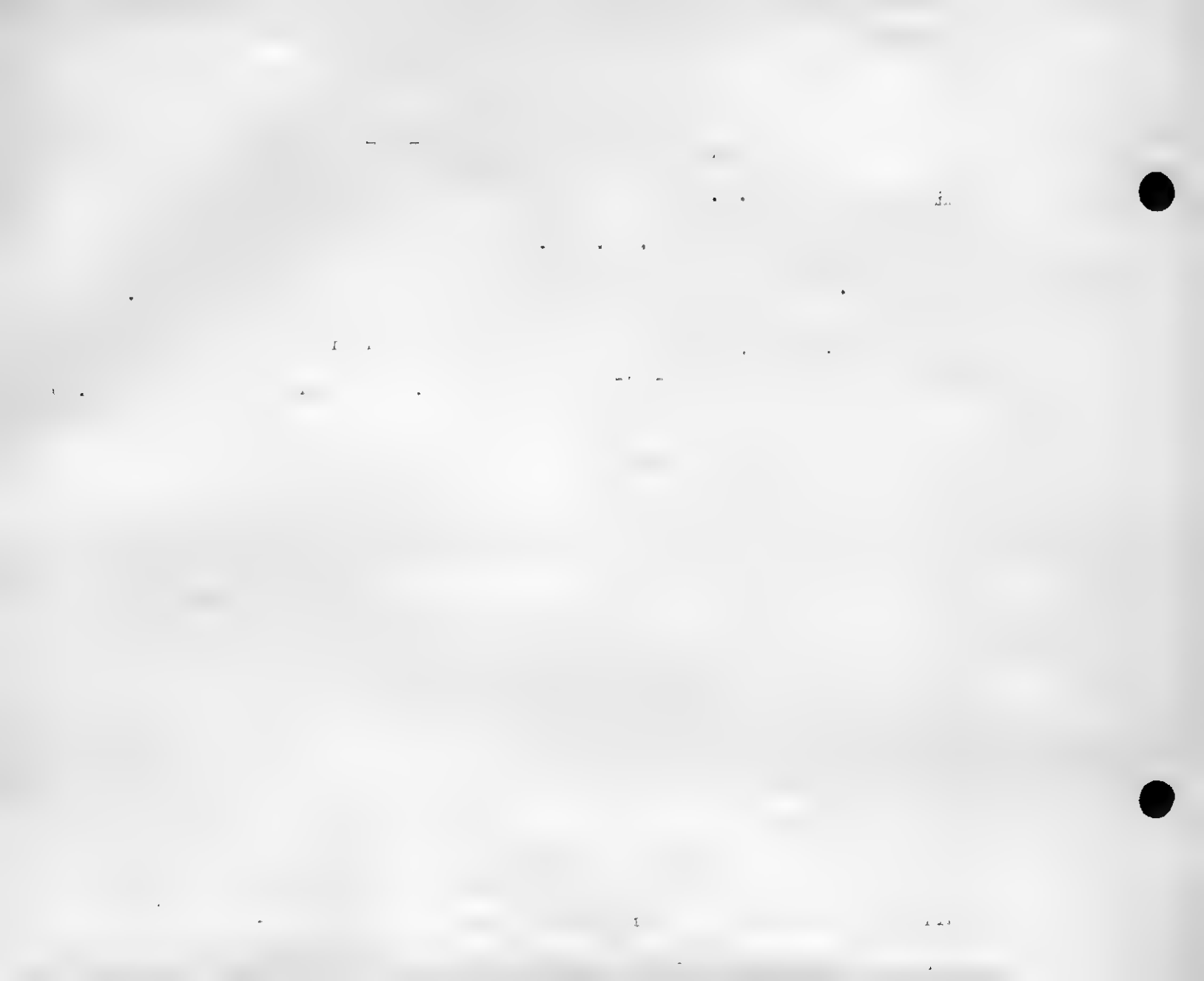


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
45M

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05145										
05137										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
David A O'Donoghue						4 Month 25 Day 69 Year		12:30 M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR		
Male		White		10-24-99		69 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Baltimore		U.S.				Baltimore County Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Randallstown			Baltimore Gen. Hospital			Carpenter				
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.			Balto		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7407 Digby Rd.	
14 FATHER'S NAME			15. MOTHER'S MA DEN NAME							
C. C. O'Donoghue			Catherine Warthen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT Address					
WW1			214-06-0553		Dorothy M. O'Donoghue -7407 Digby Rd. #7					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))										
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4109</u> <u>Coronary artery disease</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>2 YEARS</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY) OFFICE BUILDING ETC		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 4:15, 19 69, to 7:35, 19 69, that (I) (we) lost saw the deceased alive on 4-25-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <u>Ignacio Papan</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-25-69		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		4-29-69		Lorraine Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Armacost Funeral Chapel-4600 Liberty Hts						DATE APR 28 1969		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05146

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05138

1. DECEASED-NAME (Type or print)			First Martin	Middle S.	Lost Olson Jr.	2a. DATE OF DEATH Month Day Year 4 25 1969			2b. HOUR M		
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH 11-26-1917		6. AGE (In years last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Parkville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8100 Harford Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machine operator			12b. KIND OF BUSINESS OR INDUSTRY Armco Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8569 Water Oak Road 21234		
14. FATHER'S NAME First Middle Lost Samuel M. Olson			15. MOTHER'S MAIDEN NAME First Middle Lost Sarah League								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes No Yes			16b. SOCIAL SECURITY NO. W.W.11 213-03-9318		17. INFORMANT Mrs Dorothy Olson 8569 Water Oak Road 21234						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 4123 IMMEDIATE CAUSE (a) <u>Barotraumal Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stage 4 Hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 min. 2 yr. 1 yr.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. no. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May 1966, to April 1969, that (I) (we) last saw the deceased alive on 4/25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u> M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/26/69			
22d. PHYSICIAN'S NAME (Type) S. Elliott Harris						22e. ADDRESS 8100 Harford Road 21234					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-28-1969		23c. NAME OF CEMETERY OR CREMATORY Moreland Park		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.					
24. FUNERAL DIRECTOR Lassahn Funeral Home 7601 Belair Road 21236						25a. REC'D BY REGISTRAR APR 29 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05147

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05139

1 DECEASED-NAME (Type or print) <i>Bertha Louise Ortman</i>			2a. DATE OF DEATH April / Month 27 Day 1969			2b. HOUR 11 50 A. M.			
3. SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>July 28 - 1880</i>		6. AGE (In years last birthday) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md			
10. CITY OR TOWN OF DEATH <i>Baltimore Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Home - 4105 Essex Rd.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>B</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>4105 Essex Rd. 21207</i>	
14 FATHER'S NAME First Middle Last <i>William Baltz</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Mary Gehb</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No</i>			
16b. SOCIAL SECURITY NO. <i>212-308160</i>			17 INFORMANT <i>Mrs. Bertha D. Cruse</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular disease</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>age</i> DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>none</i>									
19a. DATE OF OPERATION <i>4/21/69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fr R Leg</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>4:18 P.M. 4/18/1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>lying in bed</i>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) <i>Nursing Home (Catharine Robb)</i>		21f. LOCATION Street or R.F.D. No City or Town County State <i>4105 Essex Road - Baltimore, Md</i>		22a. I certify that (I) (this hospital) attended the deceased from <i>12/2, 1965</i> , to <i>4/27, 1968</i> , that (I) (we) last saw the deceased alive on <i>4/27, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Elliot M. Kowitz</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <i>Elliot M. Kowitz</i>		22e. ADDRESS <i>212 Enchanted Hills Rd. Owings Mills</i>		22c. DATE SIGNED <i>4/27/69</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-30-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>		23e. REGISTRAR'S SIGNATURE <i>William J. ...</i>	
24. FUNERAL DIRECTOR <i>Armacost Funeral Chapel-4600 Liberty Hts.</i>		25a. REC'D BY REGISTRAR <i>APR 30 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. ...</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

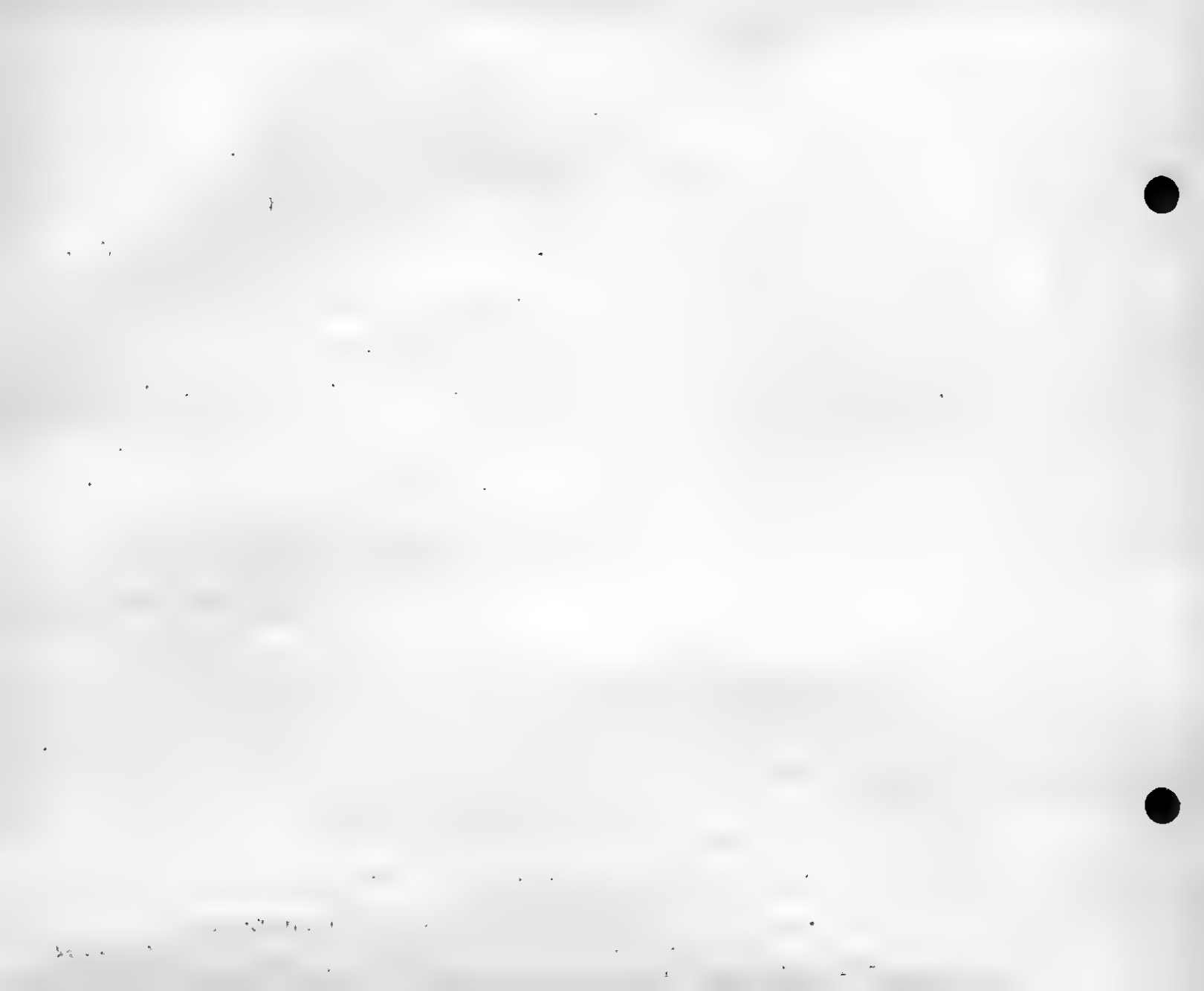
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 1 & 2 Film 411
4/14/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05148
CERTIFICATE OF DEATH

05140

1 DECEASED-NAME (Type or print) Temple		First Temple		Middle Mae		Last Osburn		2a. DATE OF DEATH Month 4			Day 3		Year 69		2b. HOUR 1:30 A.M.	
3 SEX Female		4 RACE Cau		5 DATE OF BIRTH 3/30/75				6. AGE (in years last birthday) 94 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		MIN		
7a. BIRTHPLACE (State or foreign country) Tenn		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore										
10 CITY OR TOWN OF DEATH Woodlawn		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 126 Woodlawn Ave				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Own Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission). STATE Florida		13b. COUNTY Md		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Same as #11		13f. NEAR Northeast		13g. ZIP CODE 20711				
14 FATHER'S NAME First William		Middle Weaver		Last Weaver		15. MOTHER'S MAIDEN NAME First Virginia		Middle Edwards		Last Edwards						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address Anna Lee Muhn 138 NE 26th St Miami, Fla										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Decompenation</u> 4/7/69 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo 20 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State						
22a. I certify that (I) (this hospital) attended the deceased from 8-28, 1961, to 4-3-1969, that (I) (we) lost saw the deceased alive on 4-1-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Wilmer K. Gallagher Sr. M.D.		DEGREE		ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR		<input type="checkbox"/> STAFF PHYS		22c. DATE SIGNED 4/3/69						
22d. PHYSICIAN'S NAME (Type)		Wilmer K. Gallagher Sr M.D.				22e. ADDRESS 6209 Frederick Ave Balt Md 21228										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/7/69		23c. NAME OF CEMETERY OR CREMATORY Miami City Cemetery				23d. LOCATION (City or Town) (County) (State) Miami Florida								
24 FUNERAL DIRECTOR Wm. Cook-Brooks		1050 York Road Towson Inc Balt. Md. 21204				25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge								



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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05149

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05141

1 DECEASED NAME (Type or print) First Middle Last JESSIE E PAINTER			2a DATE OF DEATH 4 Month 4 Day 69 Year		2b HOUR 6:45 P
3. SEX FEMALE	4 RACE CAUCASIAN	5 DATE OF BIRTH 4-26-1890		6 AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) New York	7b CITIZEN OF WHAT COUNTRY? USA	B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GREAT. BALT. MED. CENT.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Baltimore	13c CITY OR TOWN Baltimore	3a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13a STREET AND NUMBER 7208 Park Drive
14 FATHER'S NAME First Middle Last James Fraser			15 MOTHER'S MAIDEN NAME First Middle Last Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown (If yes give war or dates of service) No		16b SOCIAL SECURITY NO.		17 INFORMANT Address Mr. Robert L. Painter, 7414 Phila. Rd. 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESSENTIAL HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)	
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from 3-26 , 19 69 , to 4-4 , 19 69 , that (I) (we) last saw the deceased alive on 4-4 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Dr. George Pikler, MD		22c DATE SIGNED 4-4-69		22d. PHYSICIAN'S NAME (Type) DR. GEORGE PIKLER	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4/8/69.		23c NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24 FUNERAL DIRECTOR 5 RUCIC INC 5305 HARFORD RD.		ADDRESS		25a REC'D BY REGISTRAR APR 7 1969	
25b REGISTRAR'S SIGNATURE J Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515
30M REV 1/68

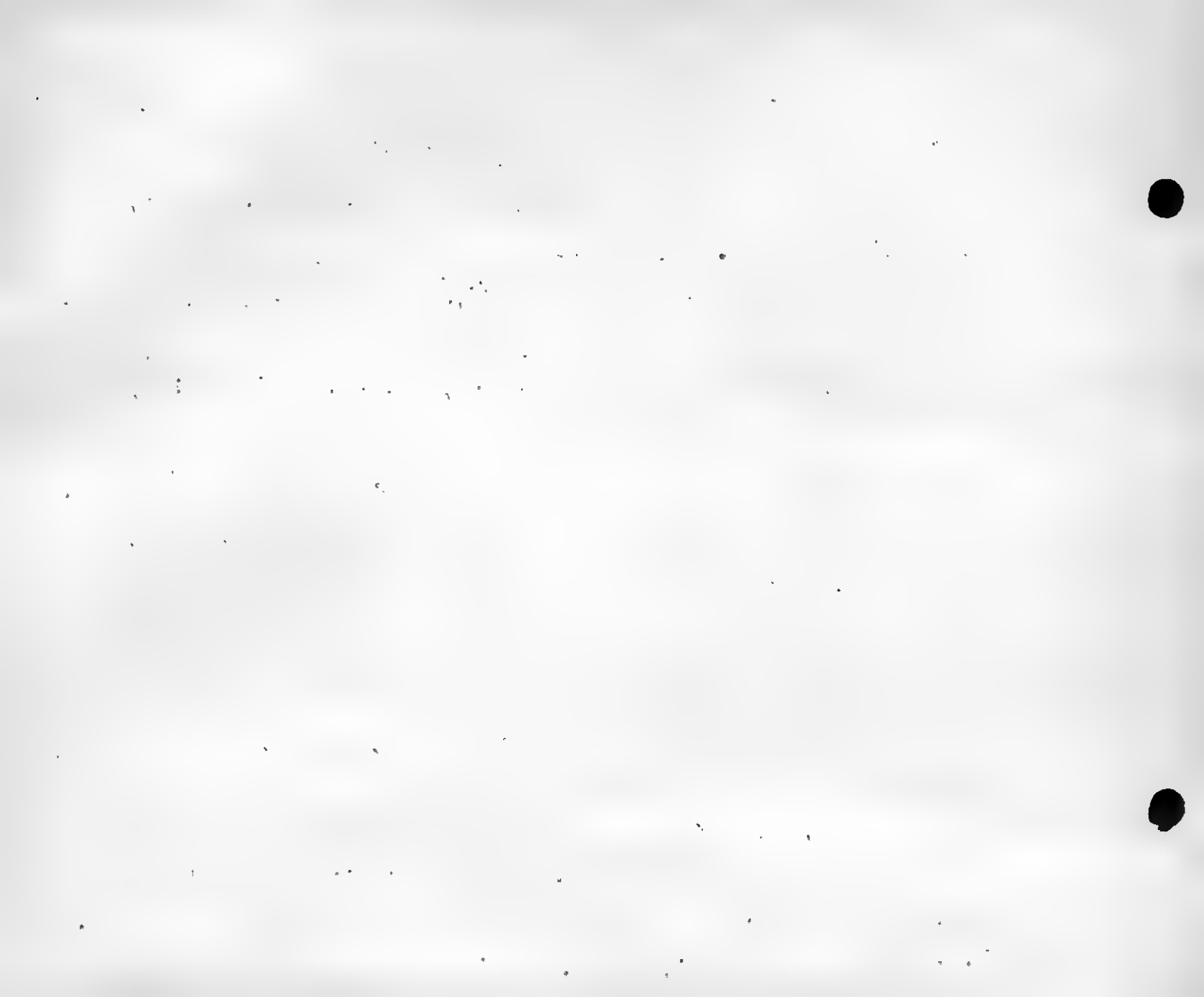
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First <i>Irvin</i>	Middle <i>Clyde</i>	Last <i>Palmer</i>	2a DATE OF DEATH Month <i>April</i> , Day <i>20</i> , Year <i>69</i>			2b. HOUR <i>2:15^P</i> M.
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>August 4, 1895</i>		6. AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Balto. Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Baltimore</i> Md.			
10. CITY OR TOWN OF DEATH <i>Reisterstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>13 Butler Road</i>			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) <i>Superintendent</i>			12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Reisterstown</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>13 Butler Road</i>	
14 FATHER'S NAME First <i>Hiram</i>			Middle <i>V.</i>	Last <i>Palmer</i>	15. MOTHER'S MAIDEN NAME First <i>Lydia</i>			Middle <i>E.</i>	Last <i>Shaffer</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give year or dates of service) <i>WW I</i>		16b SOCIAL SECURITY NO <i>212-10-8061</i>		17 INFORMANT Address <i>Mrs. Bessie E. Palmer Reisterstown</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>									<i>5 mins.</i>
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) <i>Arteriosclerotic C.V. Disease</i>									<i>years</i>
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 22, 1969</i> , to <i>Apr. 20, 1969</i> , that (I) (we) last saw the deceased alive on <i>Apr. 1, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Martin E. Strobel, M.D.</i>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-21-69</i>
22d. PHYSICIAN'S NAME (Type) <i>Martin E. Strobel, M.D.</i>					22e. ADDRESS <i>59 Hanover Rd. Reisterstown, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>April 23, 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>All Saints Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Reisterstown, Md.</i>		
24. FUNERAL DIRECTOR <i>J. F. Eline & Sons Reisterstown, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>APR 23 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William A. Budge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05151		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05143	
1. DECEASED-NAME (Type or print) WILLIAM Joseph PARSONS						2a. DATE OF DEATH Month 4 Day 1 Year 1969	
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7-18-03		6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.	
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET AND NUMBER 629 E 36th Street	
14. FATHER'S NAME First Guy Middle PARSONS Last STELLA		15. MOTHER'S MAIDEN NAME First GALLAGHER Middle GALLAGHER Last GALLAGHER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) NO			
16b. SOCIAL SECURITY NO. 215-03-0686		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE COR pulmonale 011.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RESPIRATORY FAILURE (ASPIRATION pneumonia) DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBSTRUCTIVE AIRWAY DISEASES							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) Suspect pulmonary tuberculosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/26 19 67 to 4/1 19 69 , that (I) (we) last saw the deceased alive on 4/1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. Newcomer		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE-SIGNED 4/1/1969	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/4/1969		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DR		25b. REGISTRAR'S SIGNATURE Charles Judge	



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05152

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05144

1. DECEASED NAME (Type or print) CHARLES ROBERT PAYNE			2a. DATE OF DEATH APRIL Month 7 Day 1969			2b. HOUR 8:45 M	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH July 3, 1917		6. AGE (In years last birthday) 51 YRS.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GR. BALTO. MED. CENTER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Roofing Mechanic-Hopkins		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER University		13f. 4003 Chesterfield Ave.					
14. FATHER'S NAME First Charles W. Middle Payne Last			15. MOTHER'S MAIDEN NAME First Mamie Middle Engelmann Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes Navy, WW 2		16b. SOCIAL SECURITY NO. 2 219-01-4271		17. INFORMANT Address Rita Schraudner Payne, wife, above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) COMA 1990 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MULTIPLE CARCINOMABOSIS DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 MONTHS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/13/1969 , to 4/7/1969 , that (I) (we) last saw the deceased alive on 4/7/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Neeraja Thakur				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/7/69	
22d. PHYSICIAN'S NAME (Type) DR. NEERAJA THAKUR				22e. ADDRESS 6701 N. CHARLES ST.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/10/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane				25a. REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

05153

CERTIFICATE OF DEATH

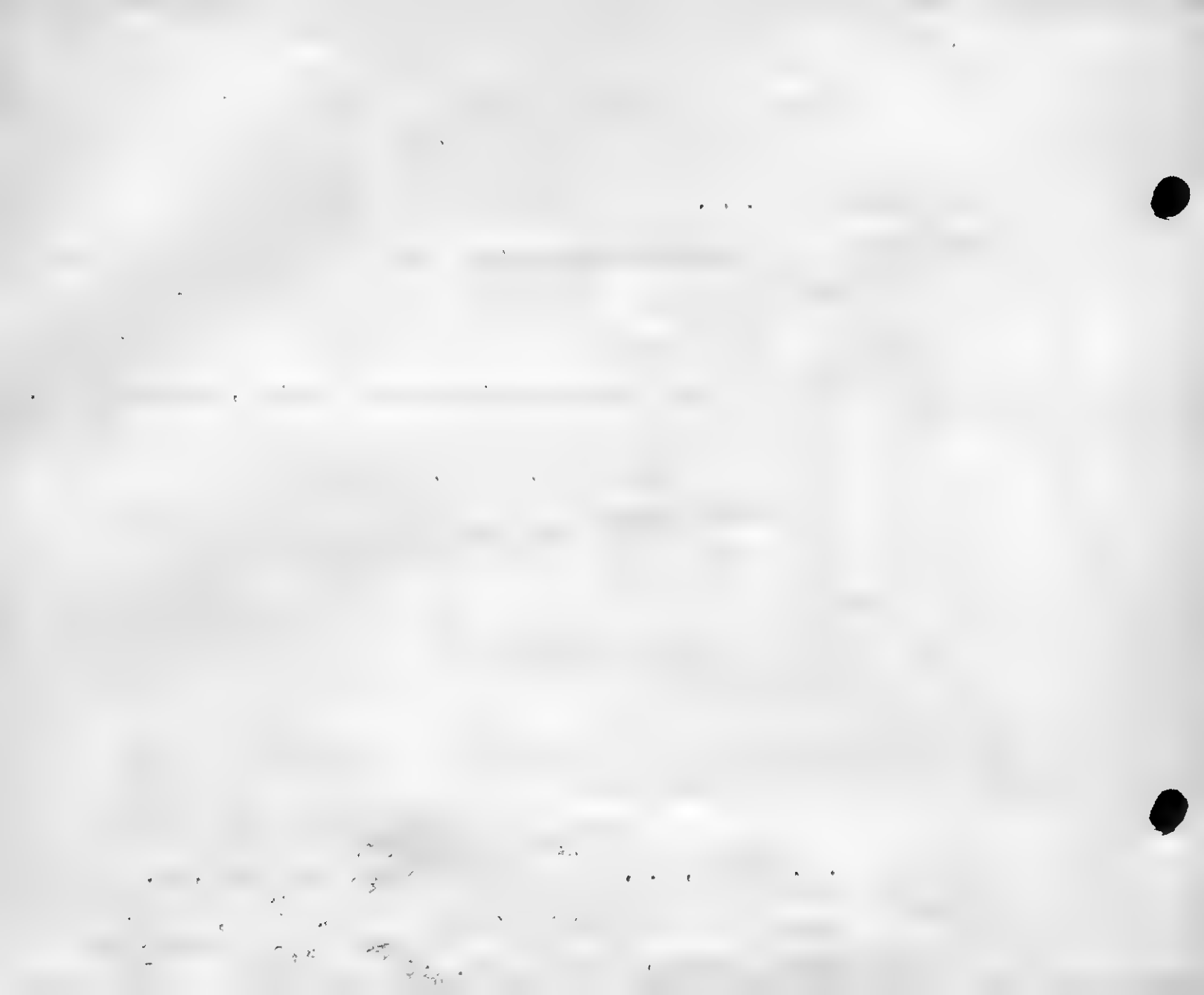
MEDICAL CERTIFICATION

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1 **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

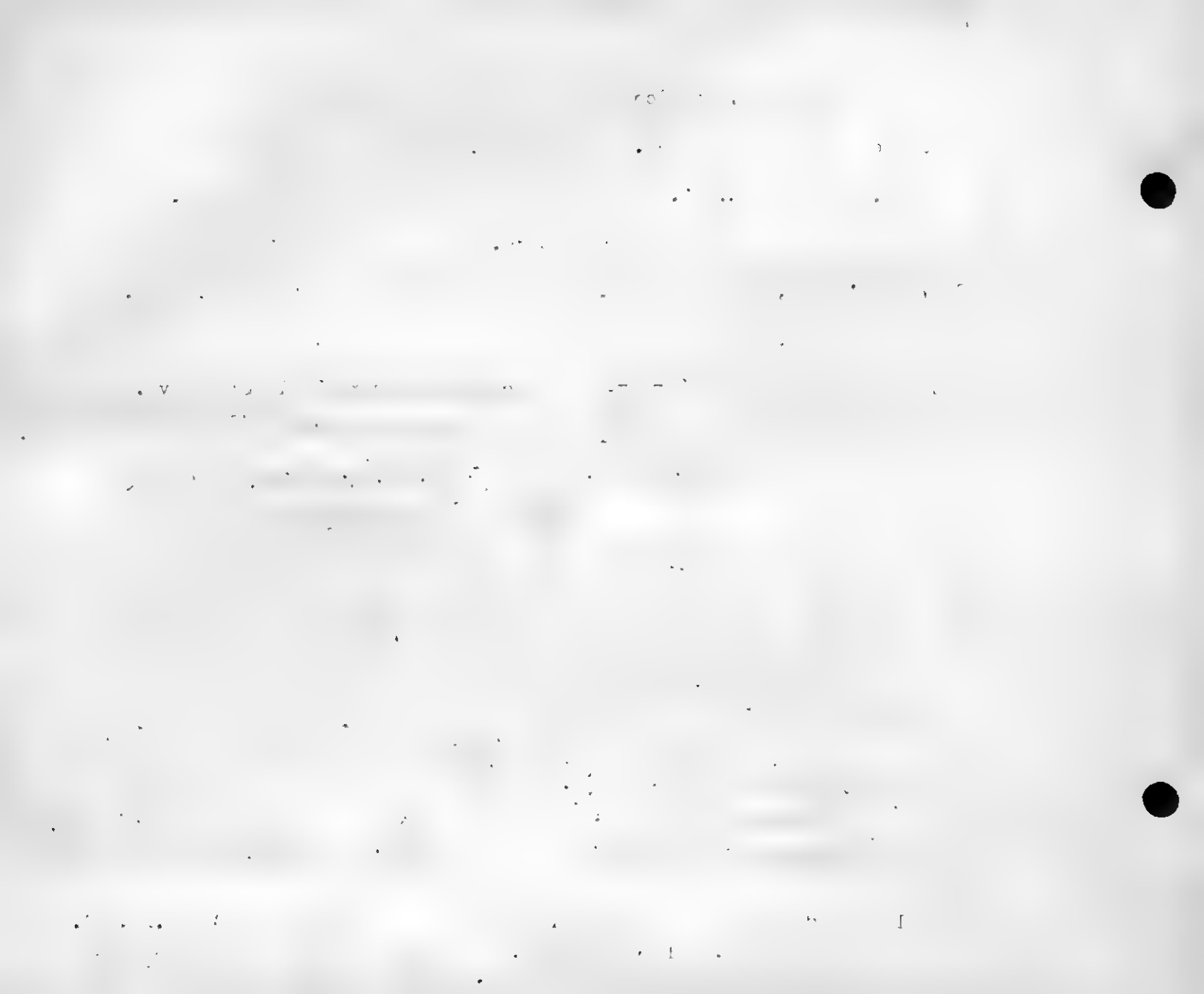
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
WILLIAM MARION PEARSON						April Month 1 Day 1969 Year		7:50 M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		6/22/08		80 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				BALTIMORE				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
FORT HOWARD		ADMINISTRATION HOSPITAL		MAIL ROOM CLERK		NEWS PAPERS				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND				BALTIMORE				823 EUTAW STREET		
14. FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last	
WILLIAM PEARSON						GRACE BITTLE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
YES		WW-11		212 03 1436		Clinical Rcds VA Hospital, Fort Howard, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE										
(c) PULMONARY EMPHYSEMA										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B)						
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION		Street or R.F.D. No.		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (X) (this hospital) attended the deceased from Mar 17, 19 69, to April 1, 19 69, that (X) (we) lost the deceased on April 1, 19 69, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death										
22b SIGNATURE						22c DATE SIGNED				
J. D. Talbert, M.D.						4/1/69				
22d PHYSICIAN'S NAME (Type)						22e ADDRESS				
J. D. TALBERT, M.D.						VA Hospital, Fort Howard, Md.				
23a BURIAL CREMATION, (Type)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		4-4-69		Baltimore Cemetery		Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS						25a BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE		
RUCK FUNERAL HOME 5305 Harford Rd Balto, Md.						APR 3 1969		[Signature]		



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05155		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05147	
Item 10 Film 411 4/15/69 kk		CERTIFICATE OF DEATH					
1 DECEASED-NAME (Type or print)		First		Middle		Last	
Mary L. Peddicord							
2a DATE OF DEATH		4/3/69		Month		Day Year	
2b. HOUR						M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female		Cauc.		1/16/1885		84 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Md.		U.S.A.				Balto. Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		2507 Harwood Rd.		Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
2507 Harwood Rd.		Balto.				2507 Harwood Rd.	
14. FATHER'S NAME		First		Middle		Last	
15. MOTHER'S MAIDEN NAME		First		Middle		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address	
No		220-05-8537		Gerald Peddicord		3441 Roland Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a)							
DUE TO, OR AS A CONSEQUENCE OF							
Acute myocardial infarction 48 hr.							
DUE TO, OR AS A CONSEQUENCE OF							
Arteriosclerotic Cardiovascular							
DUE TO, OR AS A CONSEQUENCE OF							
Generalized atherosclerosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/3/69 to 4/3/69, and that (I) (we) last saw the deceased alive on 4/3/69, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
FRANK T. KASIK						4/5/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
		7005 HARFORD RD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		4/7/69		Poplar Grove		Warren Balto. Co. Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Paul E. Chenoweth		3rd. 3617 Chestnut Ave		APR 10 1969		Charles Young	



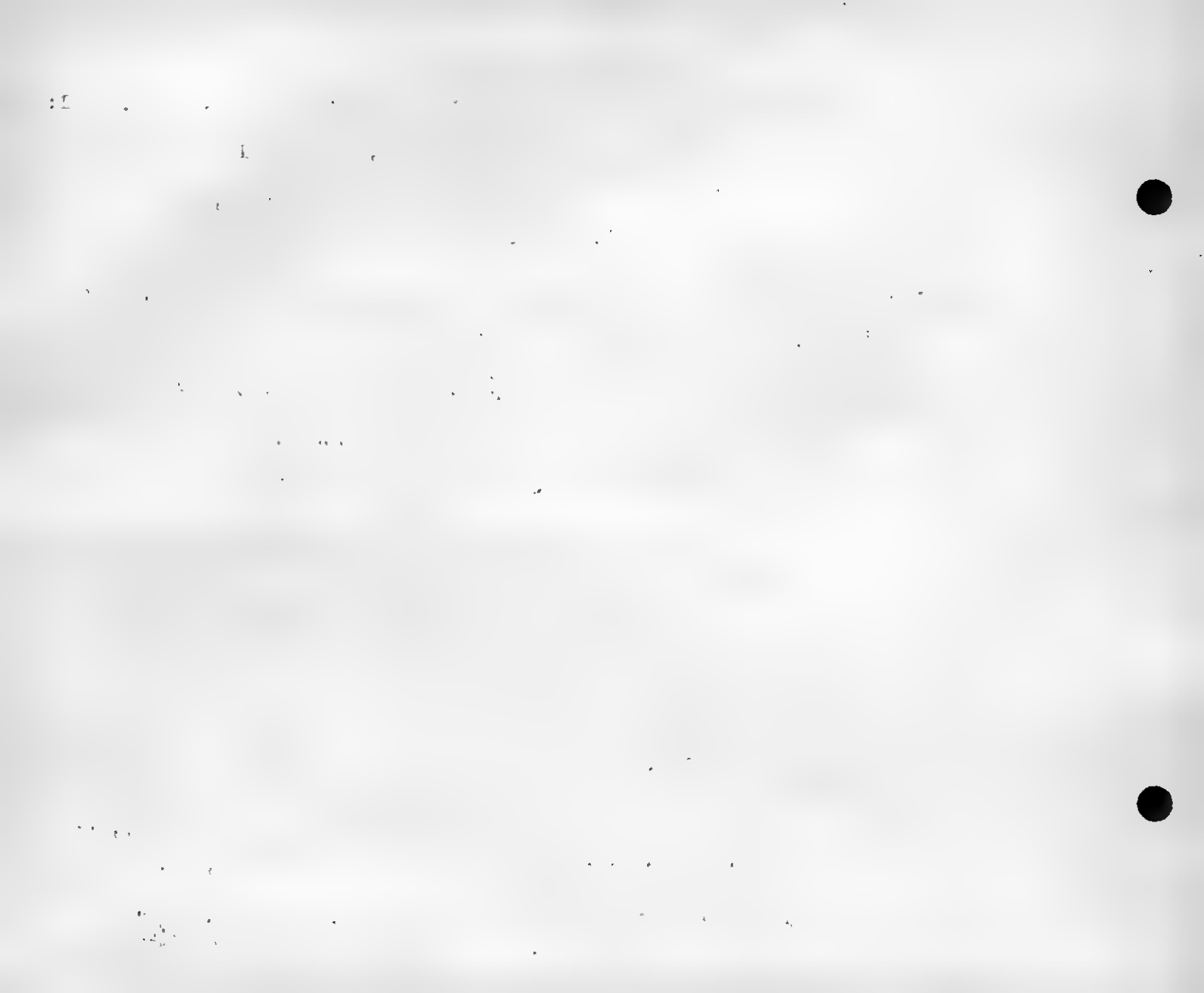
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
30M REV. 1-78

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR						
GIOVANNA			PELLEGRINI			APRIL Month 7, Day 1969 Year			1:05A						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
FEMALE		WHITE		JANUARY 18, 1888			81 YRS.		MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md			
Italy			USA						BALTIMORE,						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
TOWSON			ST. JOSEPH HOSPITAL			HOMELAKER									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
MARYLAND						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4206 BERGER AVE. #21206					
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last											
THOMAS				Di BONA.				ANTONIA				SALUVCCI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17 INFORMANT Address									
NO				217-09-2840		NICHOLAS PELLEGRINI 4206 BERGER AVE.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE AND PNEUMONIA															
4124 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
				19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (A) (this hospital) attended the deceased from March 23, 1969, to April 7, 1969, that (X) (we) lost the deceased alive on April 7, 1969, and that in (MAY) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.															
22b. SIGNATURE								DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
Beatriz P. Dizon												April 7, 1969			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS							
Beatriz P. Dizon, M.D.								7620 York Road Towson, Md. #21204							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
BURIAL				APR 10 1969		HOLY REDEEMER CEMETERY				4430 BELAIR RD BALTO MD					
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
DIPPEL BROS INC				1110 BELAIR ROAD				APR 9 1969		Charles Judge					

MEDICAL CERTIFICATION

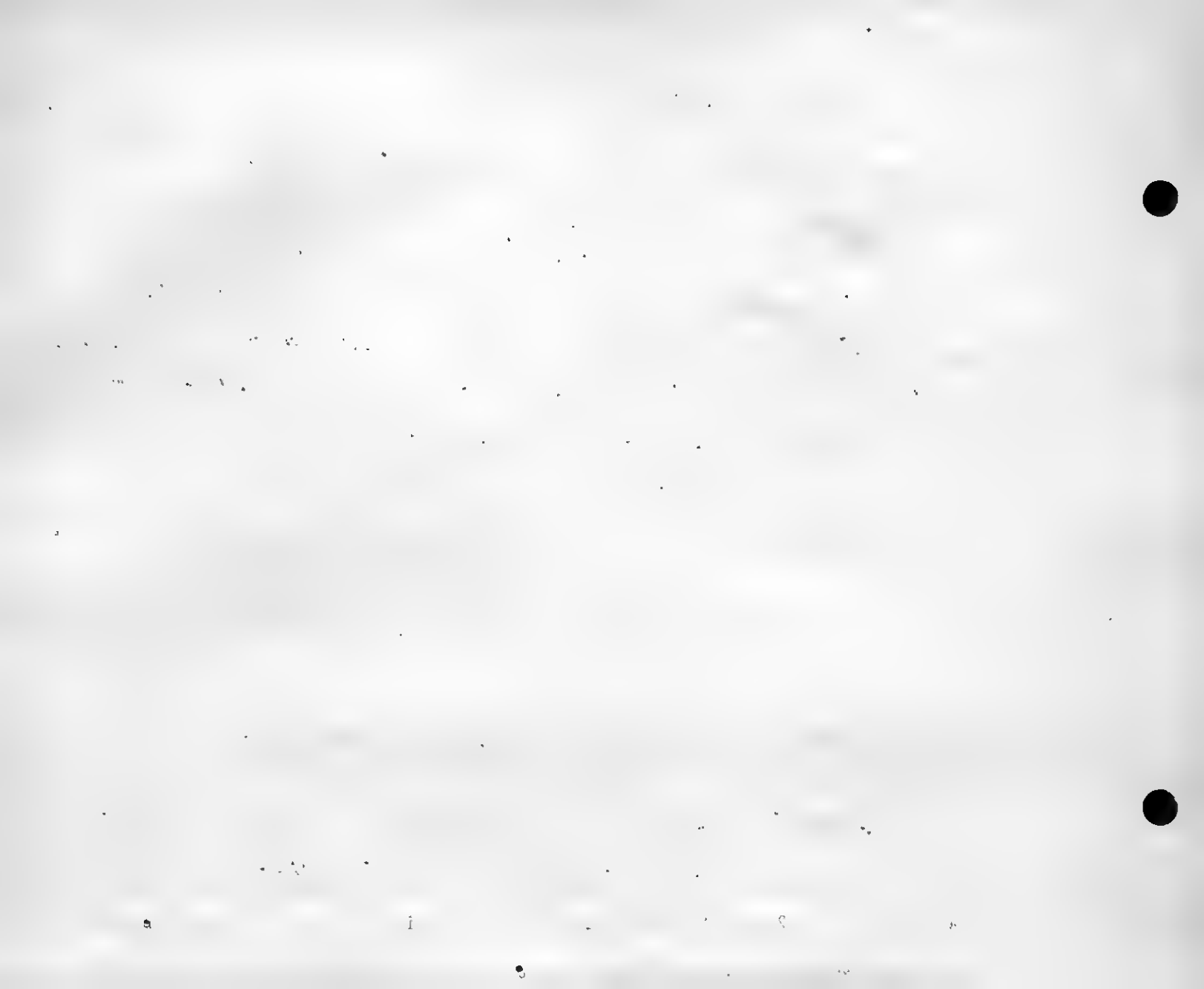


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
30M REV 4-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) ROY ELDON PERRY					2a. DATE OF DEATH Month April Day 22nd Year 1969			2b. HOUR 10:00 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH SEPTEMBER 12 1889		6. AGE (In years last birthday) 79 YRS.		7. UNDER 1 YEAR MONTHS 1 DAYS 10 HOURS 00 MIN.	
7a. BIRTHPLACE (State or foreign country) FERRISBURG VT		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH Phoenix		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Paper Mill Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Phoenix		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER PAPER MILL ROAD	
14. FATHER'S NAME First ALBERT Middle PERRY Last PERRY				15. MOTHER'S MAIDEN NAME First SOPHARONIA Middle - Last COYER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-32-7867		17. INFORMANT Address MRS. LEAH S. PERRY (wife) Phoenix, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis complicated 4539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 18th , 19 69 , to April 22 , 19 69 , that (I) (we) last saw the deceased alive on April 22nd , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE Henry M. Corkle		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-23-69					
22d. PHYSICIAN'S NAME (Type) Henry M. Corkle MD		22e. ADDRESS Phoenix, Maryland (21131)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-25-1969		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland			
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-B ooks Towson 1050 York Road 21204				25a. REC'D BY REGISTRAR APR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 yrs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
WINIFRED			A.		PETERSEN				Month 4	Day 22
									Year 1969	2b. HOUR 8:00aM
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR	
Female		Caucasian		12/10/26			42 YRS		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Baltimore		7/30				Baltimore Md				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Towson, Md.			Greater Balto. Med. Center			Clerical		Jordan Dry Cleani		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.			Baltimore		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21220 ng 50 Dogwood Drive	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Sylvester Deverell			Jane Donahur							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT Address				
			216-20-5470			Randolph A. Petersen, son, above				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) Cerebral edema and subarachnoid hemorrhage										
2050 DUE TO, OR AS A CONSEQUENCE OF										
(b) Hypophysectomy										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
4/18/69		Acromegaly			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 4/15, 1969, to 4/22, 1969, that (I) (we) last saw the deceased alive on 4/22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE		22c. DATE SIGNED								
		4/22/69								
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS								
Rudiger Breitenecker, M. D.		Greater Baltimore Medical Center								
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		4/25/69		Barkwood Cemetery		Baltimore, Md.				
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE						
Schimunek Funeral Home, Inc.		APR 25 1969		Charles Judge						
3331 Brehms Lane										



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

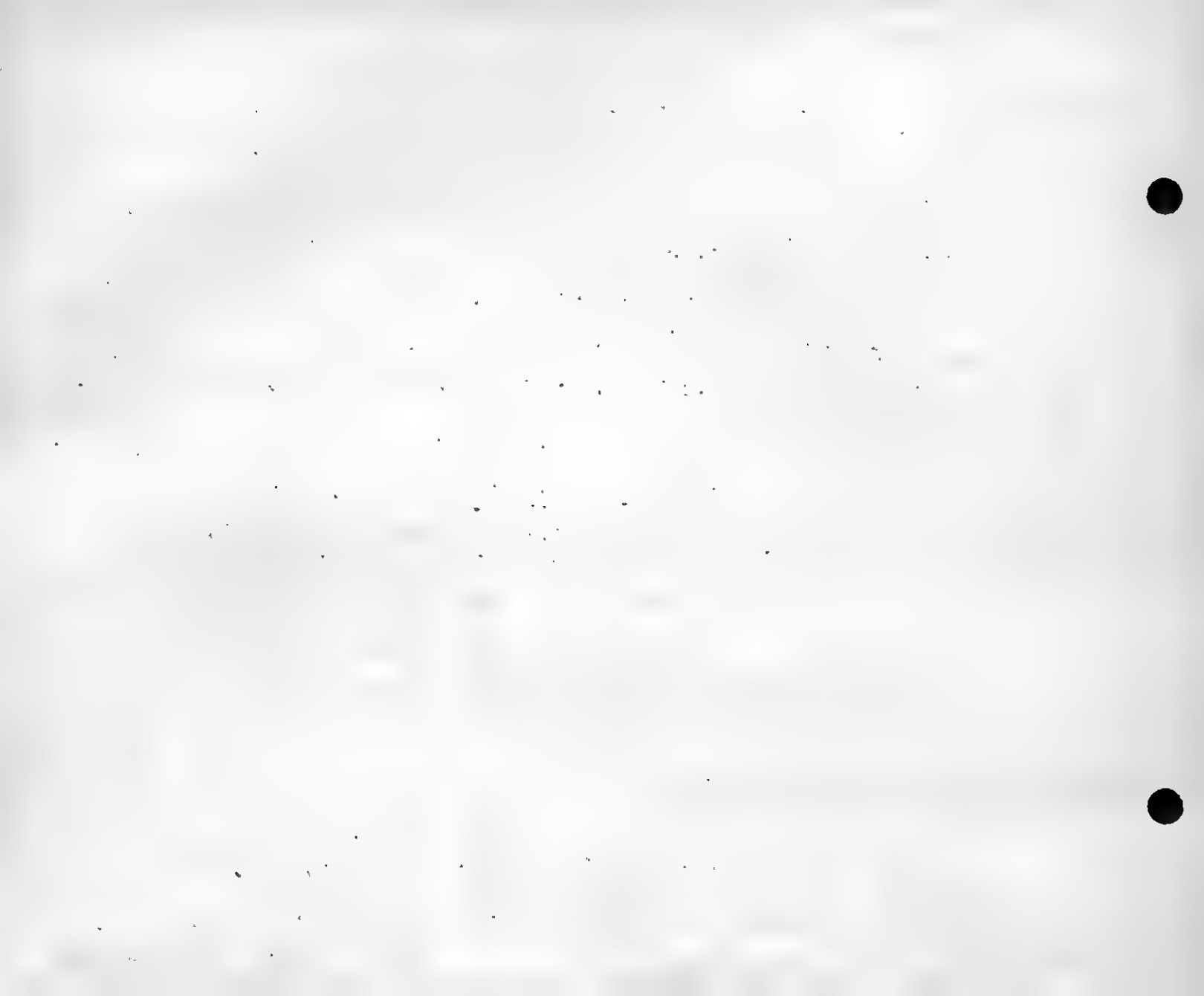
05159

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05151

1. DECEASED NAME (Type or print) First Middle Last Hazel Mae Phillips			2a. DATE OF DEATH Month Day Year April 2 1969		2b. HOUR 11 ^{PM}
3. SEX F	4. RACE W		5. DATE OF BIRTH 1-22-07		6. AGE (in years last birthday) 62 YRS.
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Aut.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md		13b. COUNTY Pr Geo	13c. CITY OR TOWN Camp Springs	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6614 Veltre Drive
14. FATHER'S NAME First Middle Last Henry Britton		15. MOTHER'S MAIDEN NAME First Middle Last Linda Yarger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 209-32-1378		17. INFORMANT Address Records, Mt. Wilson, State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Airway Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Melitus Cerebrovascular Accident APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-14 , 19 69 , to 4-2 , 19 69 , that (I) (we) last saw the deceased alive on 4-8-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W Newcomer		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-2-69	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Apr. 5, 1969		23c. NAME OF CEMETERY OR CREMATORY Sanborn Cemetery	
23d. LOCATION (City or Town) (County) (State) Clearfield Co. Penna.		24. FUNERAL DIRECTOR ADDRESS J. F. Eline & Sons Reisterstown, Md.			
25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 415 M
3044 REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
05160		05152									
1 DECEASED NAME (Type or print) First Minnie Middle Madelina Last Piel						2a. DATE OF DEATH Month 4 Day 12 Year 69			2b. HOUR 9.45 AM		
3 SEX Female		4 RACE white		5. DATE OF BIRTH 2-27-87		6 AGE (In years last birthday) 82 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto.					
10 CITY OR TOWN OF DEATH Randallstown			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County Gen			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk - Real Estate Office			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Balt Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Phoenix		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Bx 310 Merrymans Mill Rd.		
14 FATHER'S NAME First Middle Last Lamottee Hamilton Martyne			15 MOTHER'S MAIDEN NAME First Middle Last Mary McCoy								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO 219-28-7700		17 INFORMANT Baltimore County General Hospital						
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 188X Congestive heart failure											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) generalized carcinomatosis; urinary											
DUE TO, OR AS A CONSEQUENCE OF											
(c) bladder carcinoma											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4-2-1969 , to 4-12-1969 , that (I) (we) last saw the deceased alive on 4-12-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE JR Bateman						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-12-69			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE Apr. 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery				23d. LOCATION (City or Town) (County) (State) Woodlawn, Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road						25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE [Signature]			
Towson, Maryland 21204											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05161											
1. DECEASED-NAME (Type or print) First FANNIE Middle POMERANTZ Last						2a. DATE OF DEATH April 13 Day 1969			2b. HOUR 12:30 A		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAY 21, 1892		6. AGE (In years last birthday) 76 YRS.		7. UNDER 24 HRS. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) POLAND		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7618 LABYRINTH ROAD		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME					
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 7618 LABYRINTH ROAD					
14. FATHER'S NAME First ABRAHAM Middle LEVIN Last		15. MOTHER'S M A DEN NAME First FRIEDA Middle BRUCE Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 405-821565		17. INFORMANT MRS. FRIEDA TATELBAUM		Address 6104 Benhurst Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial Infarction											
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from OCT 25, 1968, to April 13, 1969, that (I) (we) last saw the deceased alive on April 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Manuel Levin M.D.		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/13/69					
22d. PHYSICIAN'S NAME (Type) MANUEL LEVIN, M.D.		22e. ADDRESS 6101 PARK HOTS AVE. BALTO - 15 MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE APRIL 13/69		23c. NAME OF CEMETERY OR CREMATORY ADATH ISRAEL ANSHE SFARD		23d. LOCATION (City or Town) BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD.		ADDRESS		25a. REC'D BY REGISTRAR APR 16 1969		25b. REGISTRAR'S SIGNATURE					

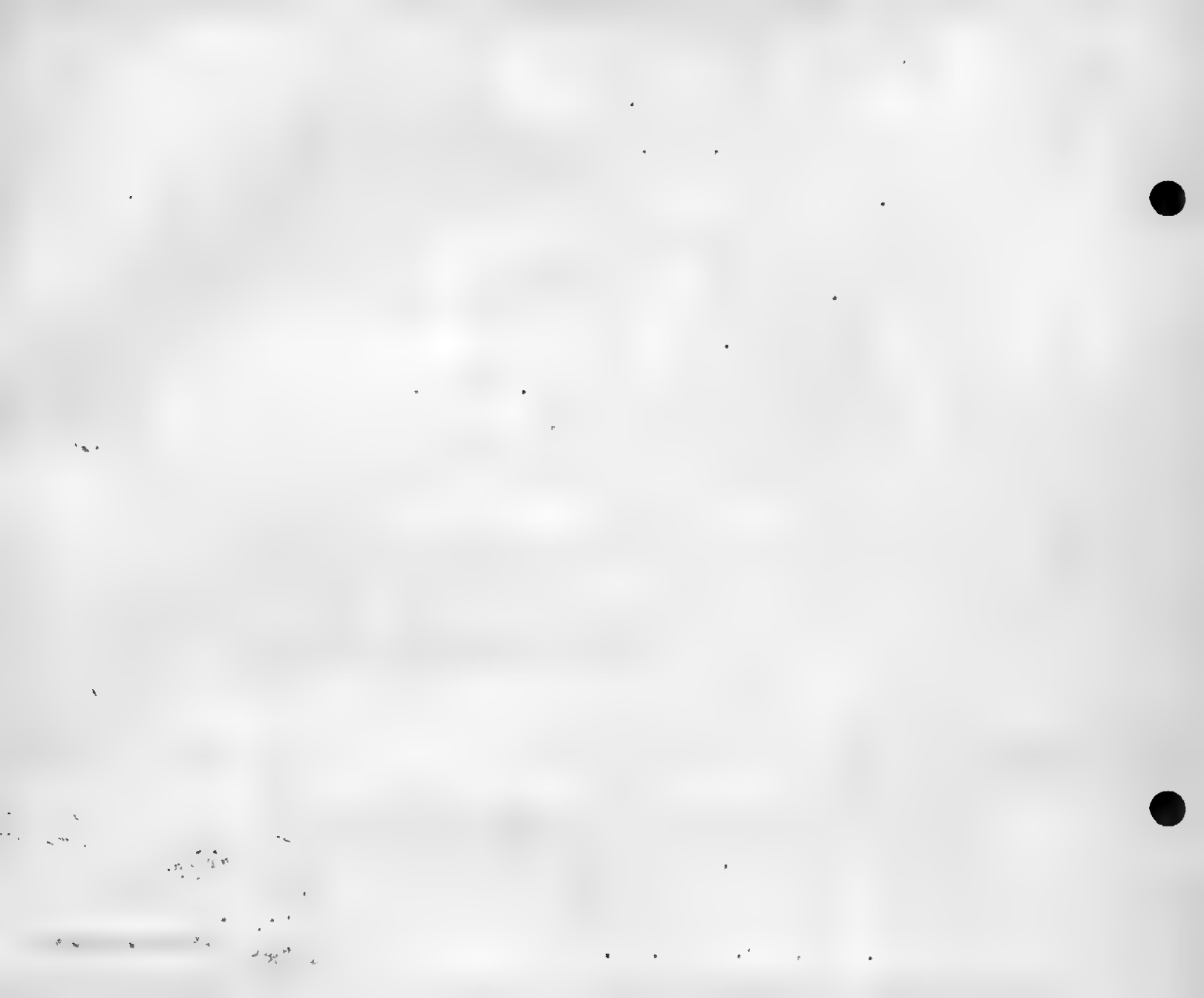
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Lost	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR	
CATHERINE		S.	POOLEY		April 12 1969					12 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year	
Female	White	May 21, 1909.	59 YRS	MONTHS	DAYS	April 12 1969				12 PM	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
Conn.	USA	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore,		Md					
1d. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Timonium		214 Sandee Drive		Housewife							
13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY, JAN 15?	13e STREET AND NUMBER						
Md.		Baltimore	Timonium	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	214 Sandee Drive						
14 FATHER'S NAME			First	Middle	Lost	15 MOTHER'S MAIDEN NAME			First	Middle	Lost
George			F.	Sheffer		Millie				Herbst	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS			
No			none		Mr. Elmer W. Pooley			(Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)											
207X											
DUE TO, OR AS A CONSEQUENCE OF											
Excess ingestion of a mixture of alcohol,											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
Phenobarbital & Librium											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
CAUSE OF DEATH		HOUR A.M. P.M. 19									
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)										4/12/69	
23a BURIAL CREMATION		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4/15/69		Moreland Memorial Park		Balto. Md.					
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Leonard J. Ruck, Inc. Balto. Md. 21214				DATE APR 14 1969		Charles J. Juge					



FOR STATE HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05163

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05155

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH				Month	Day	Year	2b HOUR		
Larry Dwight				PURKEY					4	29	1969	8:45 AM		
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR
Male	White	June 8, 1945		23 YRS	MONTHS DAYS		HOURS MIN.		Month 4 Day 29 Year 1969		8:45 AM			
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Maryland		U.S.A.				Baltimore Md								
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Owings Mills			Rosewood State Hospital			none			---					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland			Baltimore			Woodlawn			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		-----			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Wiley - Purkey			Ella - BRYANT											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS					
no			-----			Rosewood Records, Owings Mills, Md. 21117								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular Disorder											14 hrs.			
2100 DUE TO, OR AS A CONSEQUENCE OF Microcephaly											25 yrs.			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost } (b) Spastic quadriplegia														
DUE TO, OR AS A CONSEQUENCE OF (c) Phenylketonuria											25 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
none.														
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?						
none.								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
none			HOUR A.M. P.M. 19			none								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		County State			
			none.											
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASS STANT MEDICAL EXAMINER			22b DATE SIGNED					
D. D. Caples			M.D.						4-29-69					
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town or county)								
D.D. Caples, M.D.						Reisterstown, Md.								
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)			(County)		(State)		
Burial		5/1/60		St. Johns			Ellicott City			Howard		Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Higinbotham Slack			Ellicott City, Md.			MAY 2 1969			Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
SAMUEL			RAFFEL			APRIL Month 8 Day 1969 Year			10 P M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
MALE		WHITE		APRIL 20, 1900			68 YRS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND		USA					BALTIMORE Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
			7517 SLADE AVE			SELF			Business
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			BALTIMORE		BALTO			7517 SLADE AVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
MORRIS RAFFEL			FANNIE RAFFEL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address	
NO			212-03-5312		MRS REBA RAFFEL			SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>art scl cv disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4109</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>few min</u> <u>10 min</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>none</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
<u>none</u>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
<u>none</u>		<u>none</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> , 19 <u>62</u> to <u>4/8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Maurice Feldman MD</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <u>4/8/69</u>				
22d. PHYSICIAN'S NAME (Type) <u>DR. MAURICE FELDMAN JR</u>					22e. ADDRESS <u>6610 CROSS COUNTRY</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
<u>BURIAL</u>		<u>APRIL 11, 1969</u>		<u>BNAI ISRAEL</u>			<u>BALTO MD</u>		
24. FUNERAL DIRECTOR <u>Sylvan S. Lewis & Son, INC</u> ADDRESS <u>9610 Reisterstown Rd</u>				25a. REC'D BY REGISTRAR <u>APR 11 1969</u> DATE		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05165 CERTIFICATE OF DEATH 05157										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
FRANK D. RAILSBACK						April 25 1969		9:25 AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		
Male		White		January 25, 1885		84 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Indiana		U.S.A.				Baltimore Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Arbutus			1125 Linden Avenue			Conductor		B & O R.R.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Howard		Dorsey		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 417 Cedar Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Jeremiah Railsback			Elizabeth Bostock							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No			705-05-6167		Mrs. Mary D. Perrey, Box 417, Rt. 4 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-vascular disease									4 wks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) Coronary atherosclerosis									5 yrs	
(c) Cholelithiasis									10 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 1969, to Apr 25, 1969, that (I) (we) last saw the deceased alive on Apr 25, 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Dr. Bruce Brumbaugh M.D.					22c. DATE SIGNED 4/26/69		22d. PHYSICIAN'S NAME (Type)			
Dr. Bruce Brumbaugh					5609 Main Street, Elkridge, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		4-29-1969		Meadowridge Cemetery		Washington Blvd., Dorsey Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REG STRAR DATE		25b. REGISTRAR'S SIGNATURE			
Howard H. Hubbard, 4107 Wilkens Ave. 21227					APR 29 1969		Charles Judge			

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 1 & 2a Film 413
5-17-69 am DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05166

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05158

1 DECEASED-NAME (Type or Print)			First JOHN			Middle MILTON			Last RICHARDS			2a DATE KNOWN <input checked="" type="checkbox"/> OF DEATH MATED <input type="checkbox"/> Month Day Year			2b HOUR 19 M				
3 SEX Male		4 RACE White		5 DATE OF BIRTH Dec. 27, 1910		6 AGE (in years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR 4:20 P.M.				
7a BIRTHPLACE (State or foreign country) Utah				7b CITIZEN OF WHAT COUNTRY? U.S.A.				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH BALTIMORE Md.							
10. CITY OR TOWN OF DEATH Penn Motel 8729						11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Loch Bend Drive						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Executive			12b KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.						13b COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 801 Streambank Court							
14. FATHER'S NAME Gomer M. Richards						15. MOTHER'S MAIDEN NAME Sarah Butler													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16b SOCIAL SECURITY NO. (If yes give war or dates of service) 579-03-1006		17. INFORMANT Mrs. Virginia Richards						ADDRESS Same as # 13 E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial fibrosis and arteriolar sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Charles S. Springate						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						22b DATE SIGNED May 1, 1969							
EXAMINER'S NAME (Type) Charles S. Springate, M.D.						ADDRESS (Street, city, town, or county)													
23a BURIAL, CREMATION, REMOVAL, (Specify) Burial						23b DATE 5-3-69		23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery						23d LOCAT ON (City or Town) (County) (State) Pikesville Maryland					
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Towson, Md.												25a REC D BY REG STRAR DATE MAY 6 1969		25b REGISTRAR'S SIGNATURE Charles Springate					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05167									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) GEORGE FRANKLIN RICHARDSON					2a. DATE OF DEATH April Month 28 Day 1969 Year			2b. HOUR M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH March 4, 1900		6. AGE (In years last birthday) 69		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chesapeake Manor N. H.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Acct. Baltimore City		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY 13		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4029 Belwood Avenue	
14. FATHER'S NAME First George L. Richardson Middle 7 Last George L. Richardson					15. MOTHER'S MAIDEN NAME First Emma Middle Nuttrell Last Emma Nuttrell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 213-20-6745		17. INFORMANT Address 21093 Mrs. Sarah R. Slotke, 2314 Killoran Rd. Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic brain syndrome									
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF (c) Aortic aneurysm									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Nov. 11, 1968 , to April 27, 1969 , that (I) (we) last saw the deceased alive on March 26, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald O. Wood DEGREE M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-28-69		
22d. PHYSICIAN'S NAME (Type) DONALD O. WOOD, M.D.					22e. ADDRESS York Road and Greenmeadow Tr., Timonium				
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE 4-30-1969		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION (City or Town) (County) (State) Baltimore Co., Maryland			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road, 21204					25a. REC'D BY REGISTRAR APR 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

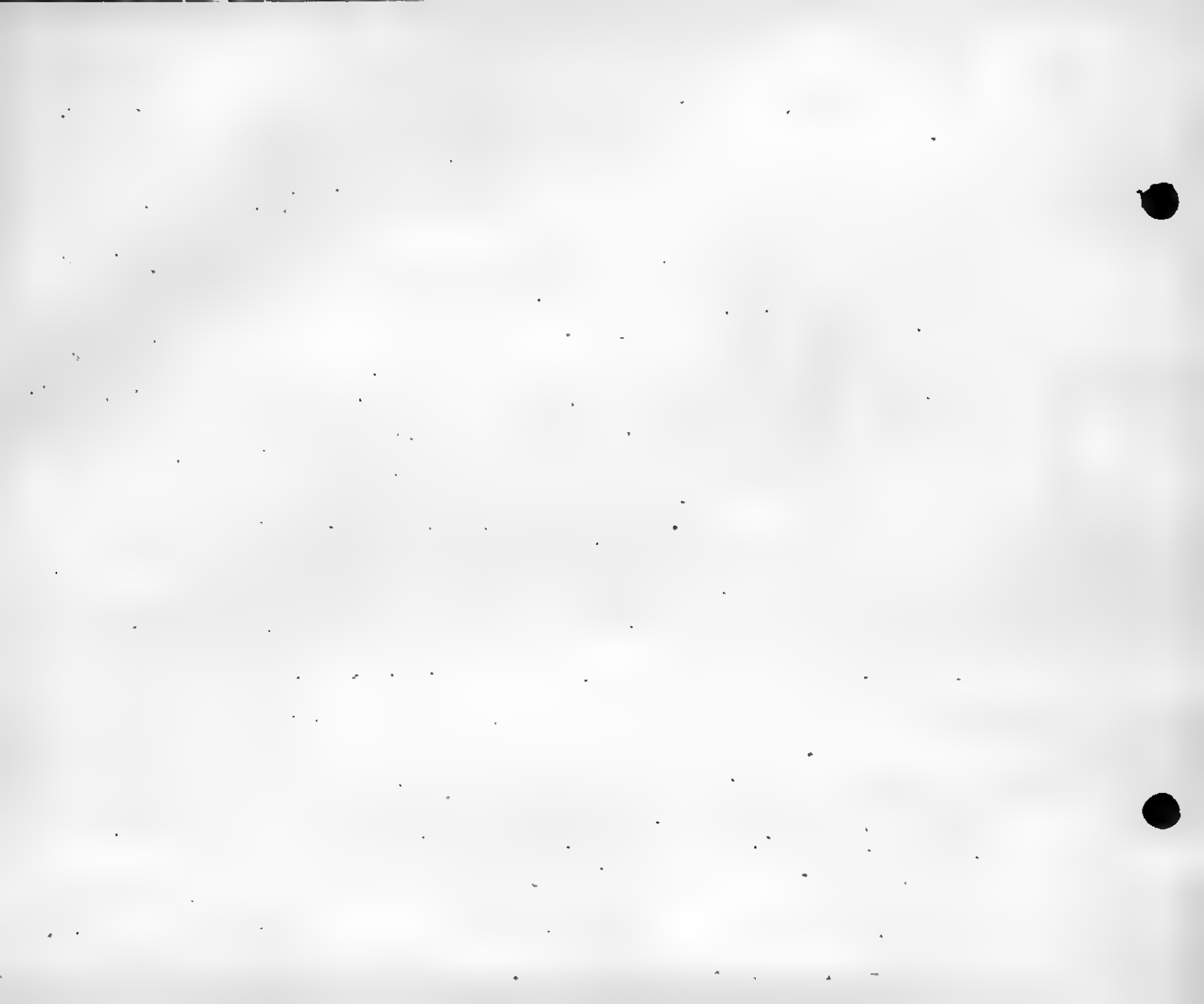
MARYLAND STATE DEPARTMENT OF HEALTH									
05168 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 23 Film G411 4/10/69 kk									
CERTIFICATE OF DEATH									
05160									
1 PLACE OF DEATH a. COUNTY <u>CATONSVILLE</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md.</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakeland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u> 329 Harlem Lane					d. STREET ADDRESS <u>3103 Savoy St. 21230</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE E. Riedel</u>					4. DATE OF DEATH <u>APRIL 1 19 69</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-1895</u> 74 yrs		9. AGE (In years last birthday) <u>74</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Lanthicum</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Russell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-09-8817</u>		17. INFORMANT <u>Catherine Donlan</u> Address <u>3103 Savoy St #30</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA c Hemiparesis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <u>Middle Cerebral artery thrombosis</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis - Chronic Bronch Syndrome</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-10-</u> , 196 <u>9</u> , to <u>4-1-</u> , 196 <u>9</u> , that (I) (we) lost the deceased alive on <u>4-1-</u> , 196 <u>9</u> , and that death occurred at <u>5 P.</u> M., from causes on and on the date stated above.									
22a. SIGNATURE <u>Cesar Valle Cuervo</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-2-69</u>		
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CUERVO</u>					22d. ADDRESS <u>3629 Liberty Rd</u>				
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 5, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Pk</u>			23d. LOCATION (City or Town) (County) (State) <u>Dorsey Howard Co. Md.</u>		
24. FUNERAL DIRECTOR <u>McCully</u> 337 Potomac Ave 21225					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
					DATE <u>APR 7 1969</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15-72
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
05169		05161							
1. DECEASED-NAME (Type or print) LULA ANNA KILL			2a. DATE OF DEATH Month April Day 29 Year 1969			2b. HOUR 11:05 AM			
3 SEX Female		4. RACE White		5. DATE OF BIRTH March 28, 1884		6. AGE (In years lost birthday) 85 YRS.		IF UNOER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH HAMPSTEAD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Falls Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN HAMPSTEAD		13d. INSIDE CITY LIM 1ST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RE #2 Falls Road	
14. FATHER'S NAME First Middle Last Joseph Davidson			15. MOTHER'S MAIDEN NAME First Middle Last Jenna Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO 213-36-7970		17. INFORMANT Mrs. Earl Martin		Address HAMPSTEAD MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Thrombosis 41 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Central Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis Cardiovascular Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 12, 1966 to April 29, 1969 , that (I) (we) lost saw the deceased alive on April 29, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph E. Bush MD		22c. PHYSICIAN'S NAME (Type) Joseph E. Bush MD		22d. ADDRESS HAMPSTEAD Maryland		22e. DATE SIGNED April 29, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/2/69		23c. NAME OF CEMETERY OR CREMATORY Wesley Cemetery		23d. LOCATION (City or Town) (County) (State) Hampstead Md.			
24. FUNERAL DIRECTOR Tipton-Eline Fun.Home		ADDRESS Hampstead, Md.		25a. REGD BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE [Signature]			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR		
TOMMIE			-		-		RISHER		APRIL 20, 1969		5:30 AM		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE		NEGRO		4/13/13			36 YRS		MONTHS DAYS		HOURS MIN.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
S. CAROLINA			U.S.A.					BALTIMORE Md					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
FORT HOWARD,				VETERANS ADMIN. HOSPITAL				LABORER			STEEL		
13a USUAL RESIDENCE (Where deceased was born, if institution residence before)				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
MARYLAND						BALTIMORE				1720 E. OLIVER STREET			
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last	
JIM			-		-		RISHER		MARY			- - PRIECE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT Address							
YES				WWII		215 10 4987		CLINICAL RECORDS, VAH, FT. HOWARD, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LEFT PLEURA WITH EXTENSIVE METASTASIS											YEARS		
1630 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE											YEARS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State							
22a I certify that (X) (this hospital) attended the deceased from APR 15, 1969, to APR 20, 1969, that (X) (we) last saw the deceased alive on APR 20, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death													
22b SIGNATURE Pushpendra Senan							ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 4 20 69				
22d PHYSICIAN'S NAME (Type) PUSHPENDRA SENAN, M.D.							22e ADDRESS VAH, FT. HOWARD, MD.						
23a BURIAL CREMATION, (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
BURIAL			April 25/69		BALTO. NATIONAL CEMETERY			BALTIMORE, MD.					
24 FUNERAL DIRECTOR ELLIOTT FUNERAL HOME							ADDRESS 1129 N. CAROLINE ST., BALTO., MD.		25a REC'D BY REGISTRAR DATE APR 21 1968		25b REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VA 15-1
304 REV 1-54

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
JOSEPH				ROCKLIN	APRIL 8, 1969		6 A.M.		
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
MALE	WHITE		9-10-1914		54 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
BALTO., MD.		U.S.A.				BALTIMORE Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
B ALTIMORE			3317 OLD POST DRIVE			CPA		SELF EMPLOYED	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MARYLAND			BALTIMORE						3317 OLD POST DRIVE
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
ABRAHAM ROCKKIND				REBECCA ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
YES				W.W. II		MRS. GERTIE ROCKKLIN, 3317 OLD POST DR. #8			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest									immediate
4107 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Atherosclerotic CV disease - acute myocardial infarction									7
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Acute myocardial infarction 1962 - Sinai Hospital									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1962, to 4/8, 1969, that (I) (we) last saw the deceased alive on Oct 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Abraham Genecin M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8 April 69			
22d. PHYSICIAN'S NAME (Type) ABRAHAM GENECIN				22e. ADDRESS 611 PARK AVENUE					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		4-8-69		ARLINGTON		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				APR 9 1969		Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05172

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05164

1 DECEASED NAME (Type or Print) MARTHA BRAYSHAW			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year April 6 1969			2b HOUR 7:15 PM				
3 SEX F		4 RACE Can		5 DATE OF BIRTH 2-22-10		6 AGE (in years last birthday) 59 YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country) Penna		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE							
10. CITY OR TOWN OF DEATH Towson				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 21131 21st W. Penna. Ave				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HAIR DRESSER				12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE MD.				13b COUNTY BALTO.		13c CITY OR TOWN Phoenix		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 98A Glenbrook Dr			
14 FATHER'S NAME Orlando			First Middle Last Brayshaw			15 MOTHER'S MAIDEN NAME MARY E CRUMICK			First Middle Last				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b SOCIAL SECURITY NO 2532-158		17 INFORMANT Kusnell T Prof. - Same as #13				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion DUE TO, OR AS A CONSEQUENCE OF Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Hypertension (b) 14 yr DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 4/6/69					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b DATE 4-7-69		23c NAME OF CEMETERY OR CREMATORY Green Mount				23d LOCATION (City or Town) (County) (State) Baltimore Md			
24. FUNERAL DIRECTOR Wm. Cook. Burial Town				ADDRESS 1058 York Rd Towson Md				25a REC'D BY REG STRAR APR 10 1969		25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
45M - 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
05173									
05165									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Rosie			Rose			April 15, 1969			7:10 a. m.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
female		Negro		Aug. 8, 1883		85 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U. S.				Baltimore Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville			SPRING GROVE STATE HOSP.			housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Harford		Belair		YES <input type="checkbox"/> NO <input type="checkbox"/>		106 Garden Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Williams			Julian						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
			219-36-2481A		Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease									
4124 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Urinary tract infection; uremia; late, latent syphilis; decubitus ulcers									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 28, 1968, to April 15, 1969, that (I) (we) last saw the deceased alive on April 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		Diomidis Pirovolidis, M.D.			ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-15-69		
22d. PHYSICIAN'S NAME (Type)		Diomidis Pirovolidis, M.D.			22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
APRIL 18-69		APRIL 18-69		Henderson Hill		Bel Air Har. Md			
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George W. Tittle		Bel Air Md			DATE APR 17 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

05174

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05166

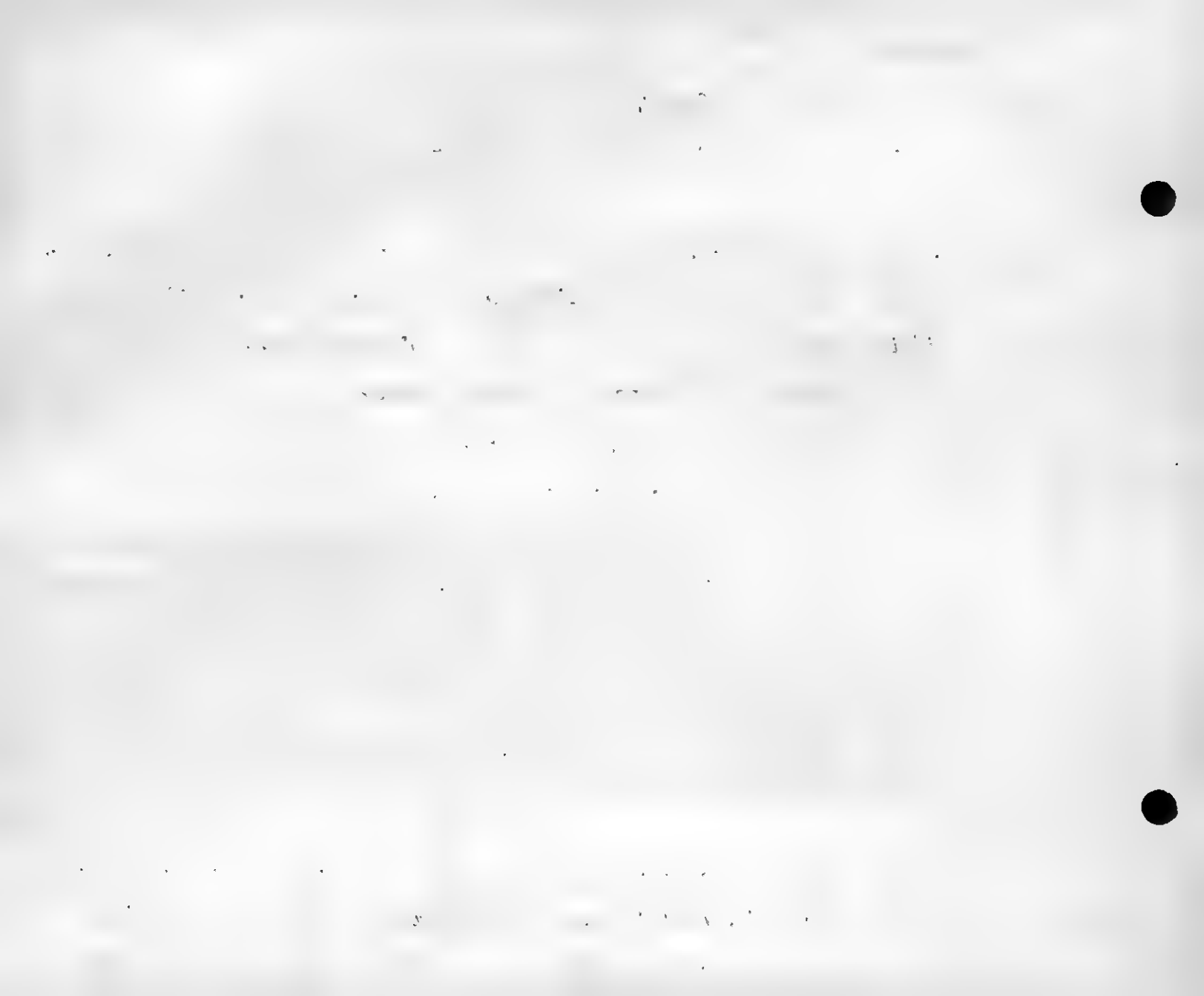
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) ARTHUR WILHELM ROSENBERGER			2a. DATE OF DEATH Month APRIL Day 28 Year 1969			2b. HOUR 4:50 a.m.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 22 March 1897		6. AGE (In years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Balto	
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) 6724 Townbrook Dr		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) Ret		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 6724 Townbrook Dr							
14. FATHER'S NAME First Leo Middle ROSENBERGER Last ROSENBERGER			15. MOTHER'S MAIDEN NAME First Hedwig Middle Rosenberger Last ROSENBERGER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 218-140644		17. INFORMANT wife Address Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kurt Kurbann M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 207 Clarendon Ave 21208			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/29/1969		23c. NAME OF CEMETERY OR CREMATORY Chesapeake Chesapeake		23d. LOCATION (City or Town) (County) (State) Randallstown Md	
24. FUNERAL DIRECTOR Sylvan S. Quisenberry				ADDRESS 9610 Reisterstown Rd		25a. DIED BY REGISTRAR APR 29 1969	
						25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Margaret Cecelia Ryan						April Month 9 Day 1969 Year			1:15					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. FUNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		11-20-1882			88 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland			USA						Baltimore			Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Towson			St. Joseph's Hospital			Homemaker			Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY & MTS?			13e. STREET AND NUMBER		
Maryland			Baltimore			Riderwood			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1622 W. Joppa Road		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
William Ryan			Margaret Howard											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No			None			None			Family records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>General arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive heart failure secondary to arteriosclerotic cardiovascular disease</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>April 4</u> , 19 <u>69</u> , to <u>April 9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE								DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
												4-9-69		
22d. PHYSICIAN'S NAME (Type) Nit Kunawongsa, M.D.						22e. ADDRESS								
						7620 York Rd., Towson, Md. 21204								
23a. BURIAL, CREMAT. OR OTHER DISPOSAL (Type)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			April 11, 1969			Dulaney Valley Memorial			Cockeysville, Maryland					
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John Bulno Sr						Towson			APR 14 1969			William Judge		



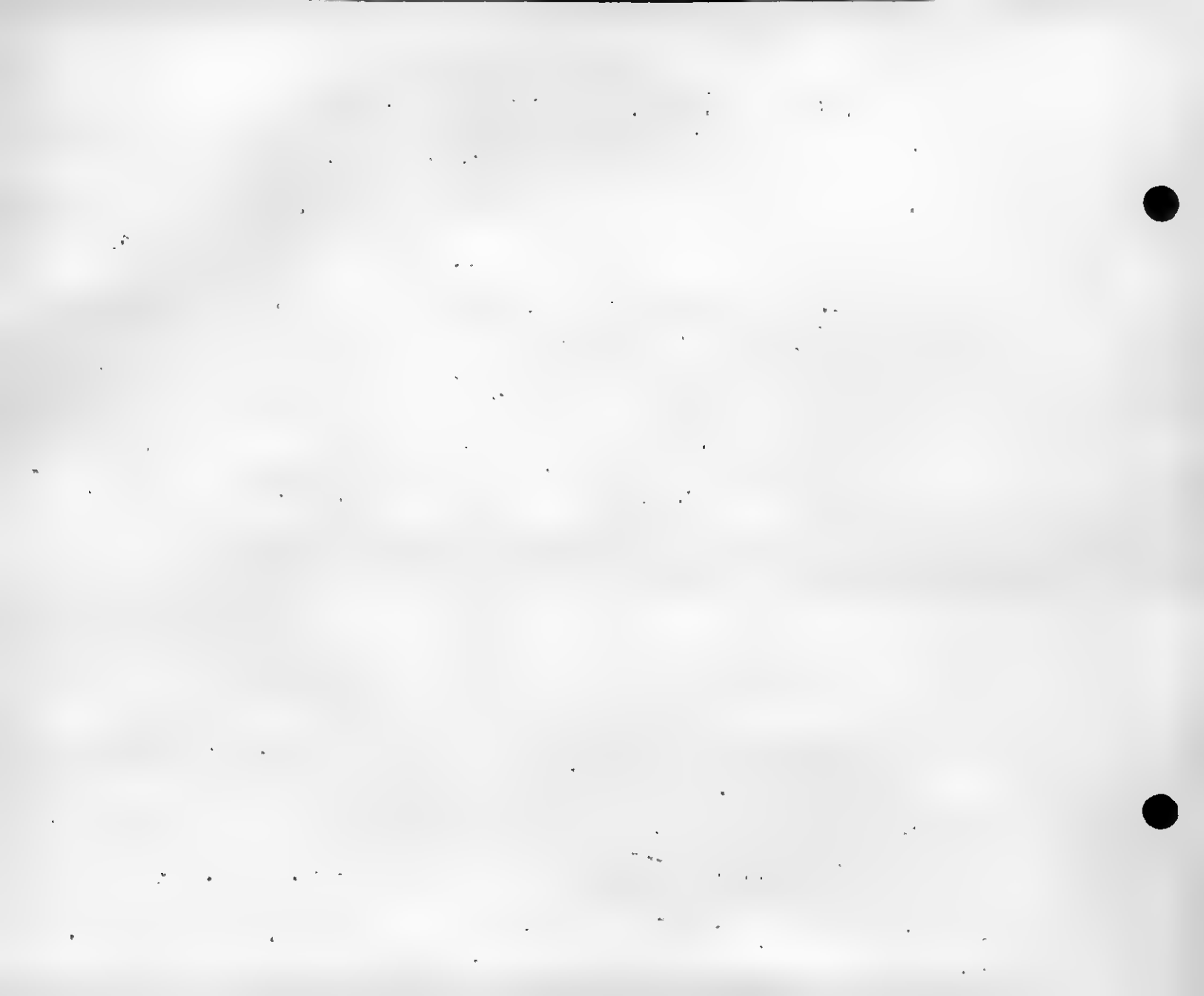
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

VR A15
30M REV. 1-68

MIDDLE													
05176						DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						05168	
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print) <i>William George Saddington</i>						2a. DATE OF DEATH <i>April 1</i> Month <i>29</i> Day <i>1969</i>				2b. HOUR <i>4:00</i> AM			
3 SEX <i>Male</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>Dec. 9 1905</i>		6 AGE (In years last birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>PA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>KINGSVILLE</i> <i>Baltimore</i> Md.							
10. CITY OR TOWN OF DEATH <i>Kingsville</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kingsville Md.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Craftsman</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>MTD</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Kingsville</i>		13d. INSIDE CITY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <i>Bellvue Avenue 21087</i>				
14 FATHER'S NAME First <i>William</i> Middle <i>Marion</i> Last <i>Saddington</i>				15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Harrison</i> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>163-09-0545</i>		17 INFORMANT <i>Marion Saddington</i> Address <i>Kingsville Md.</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>										<i>Immediate</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic CVD</i>										<i>8 yrs. +</i>			
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <i>1959</i> to <i>April 1, 1969</i> , that (I) (we) lost saw the deceased alive on <i>April 1, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.													
22b. SIGNATURE <i>William A. Tyson M.D.</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-29-69</i>					
22d. PHYSICIAN'S NAME (Type) <i>William A. Tyson</i>						22e. ADDRESS <i>Kingsville, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>5/2/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Belair Memorial</i>		23d. LOCATION (City or Town) (County) (State) <i>Bel Air Md.</i>							
24. FUNERAL DIRECTOR <i>Sessaba Turner</i>		ADDRESS <i>Baltimore Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

05177

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05169

1. DECEASED NAME (Type or print) EARL WASHINGTON SANTMYER		2a. DATE OF DEATH Month 8 Day 8 Year 69		2b. HOUR 12:45 PM		
3. SEX M	4. RACE Cauc	5. DATE OF BIRTH 3-11-53	6. AGE (In years last birthday) 16 YRS.	IF UNDER 1 YEAR MONTHS 1 DAYS 1	IF UNDER 24 HOURS HOURS 1 MIN. 1	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto Co Gen Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 710 Templecliff Rd.	
14. FATHER'S NAME First Washington Middle Santmyer Last Santmyer		15. MOTHER'S MAIDEN NAME First Emma Middle Fischer Last Fischer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If has gone war or dates of service)		17. INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral aneurysm, post metastatic DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) 1 year? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION Dec 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cx of lung		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from Mar 1968 , to April 8, 1969 , that (I) (we) last saw the deceased alive on April 5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death						
22b. SIGNATURE H. Gerard Oster MD		22c. DATE SIGNED 4/8/69		22d. PHYSICIAN'S NAME (Type) H. GERARD OSTER		
22e. ADDRESS 6821 Reisterstown Rd		23a. BURIAL, CREMATION, REMOVAL (Specify)				
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Charles Judge		ADDRESS		25a. REC'D BY REGISTRAR APR 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05178 CERTIFICATE OF DEATH 05170									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR
ANDERSON			McCLELLAN SAVOY			April 1 1969			1:25 PM
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Male		Negro		Oct. 11. 1897		71 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
FORT HOWARD			VETERANS ADMINISTRATION HOSPITAL			Handyman			Private Family
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, IN 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
MARYLAND			BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12 Jones Avenue
14 FATHER'S NAME First Middle Last			15 MOTHER'S M A DEN NAME First Middle Last						
WILLIAM H. SAVOY			EMMA A. WASHINGTON						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
YES WW-1			705 10 3231		Clinical Rcds, VA Hospital, Fort Howard, Md.				
18 CAUSE OF DEATH (Enter on any one cause per line for (a) (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, RECENT									
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMPHYSEMA, OLD									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
ADENOCARCINOMA OF PROSTATE, OLD									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from Feb. 24, 19 69, to April 1, 19 69, that (X) (we) last saw the deceased alive on April 1, 19 69, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) and (d) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
HOWARD C. KRAMER, M.D.					VA Hospital, Fort Howard, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		4-4-69		Baltimore National			Baltimore, Maryland		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert L. Snowden					DATE APR 7 1969		Charles Judge		
SNOWDEN FUNERAL HOME 246 N. Wash. St. Rockville, Md.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

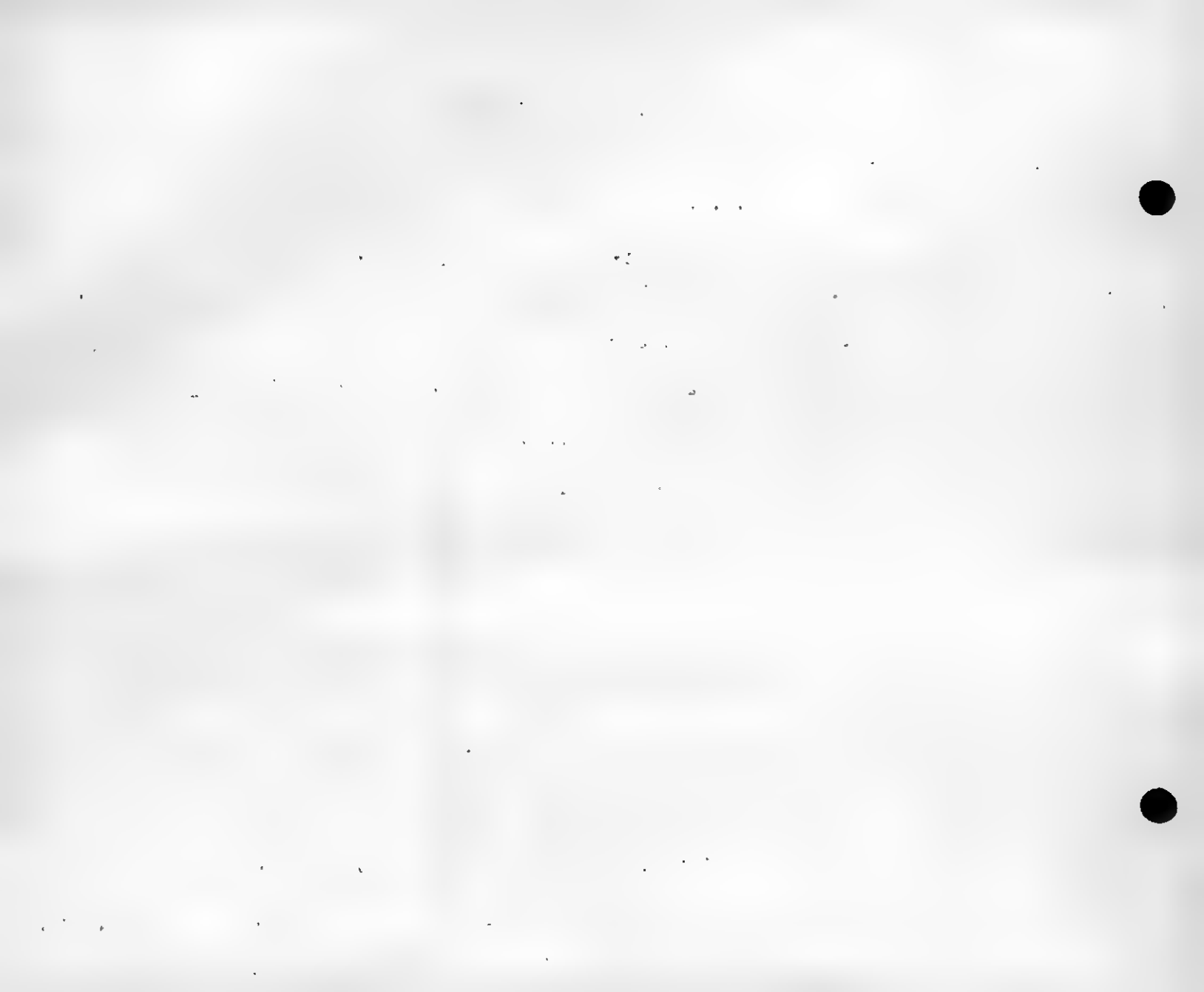
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) Anna			First Middle Last F. Schaefer			2a. DATE OF DEATH April Month 17 Day 1969.		2b. HOUR 5:15 4 M		
3 SEX Female		4 RACE White		5. DATE OF BIRTH Dec. 23, 1879.		6. AGE (In years last birthday) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore, Md.				
10. CITY OR TOWN OF DEATH Baltimore (Rural)			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armcast Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8401 Loch Raven Blvd.	
14. FATHER'S NAME First Middle Last Frederick W. Feldner			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Hoehne			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No				
16b. SOCIAL SECURITY NO. 220-44-0092			17 INFORMANT Mr. Charles Feldner			Address (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4/17/69 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs 9 yrs.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe arteriosclerotic cerebrovascular disease										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Dec, 1958, to April 17, 1969, that (I) (we) last saw the deceased alive on April 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (we) view the body after death.										
22b. SIGNATURE Joseph F. LiPira M.D.				22c. DATE SIGNED 4-18-69		22d. PHYSICIAN'S NAME (Type) Joseph F. LiPira M.D.				
22e. ADDRESS 8401 Loch Raven Blvd. Balto, Md. 21204										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/21/69.		23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.				
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REGD. BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
JAMES		E.		SCHIRMER				4 Month 14 Day 69 Year	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR	
Male		Cau.		4-3-1908		61 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Baltimore		U.S.A.				Baltimore		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		Greater Balto. Med. Center		Ret. Postal Mechanic		Postoffice			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5601 Leiden Road 21206	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Anthony		Schirmer						Anna Spahn	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No, or unknown <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address			
No		215-03-8217		Mrs Marion Schirmer		5601 Leider Avenue		06	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4124 DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/23/1969, to 4/14/1969, that (I) (we) last saw the deceased alive on 4/14/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		Charles C. Brown, M.D., DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
								4/14/69	
22d. PHYSICIAN'S NAME (Type)		Charles C. Brown, M.D.				22e. ADDRESS			
						6701 N. Charles Street			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4-17-1969		Gardens of Faith		Fullerton Balto. Md.			
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lassahn Funeral Home		7401 Belair Road 21236				APR 16 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

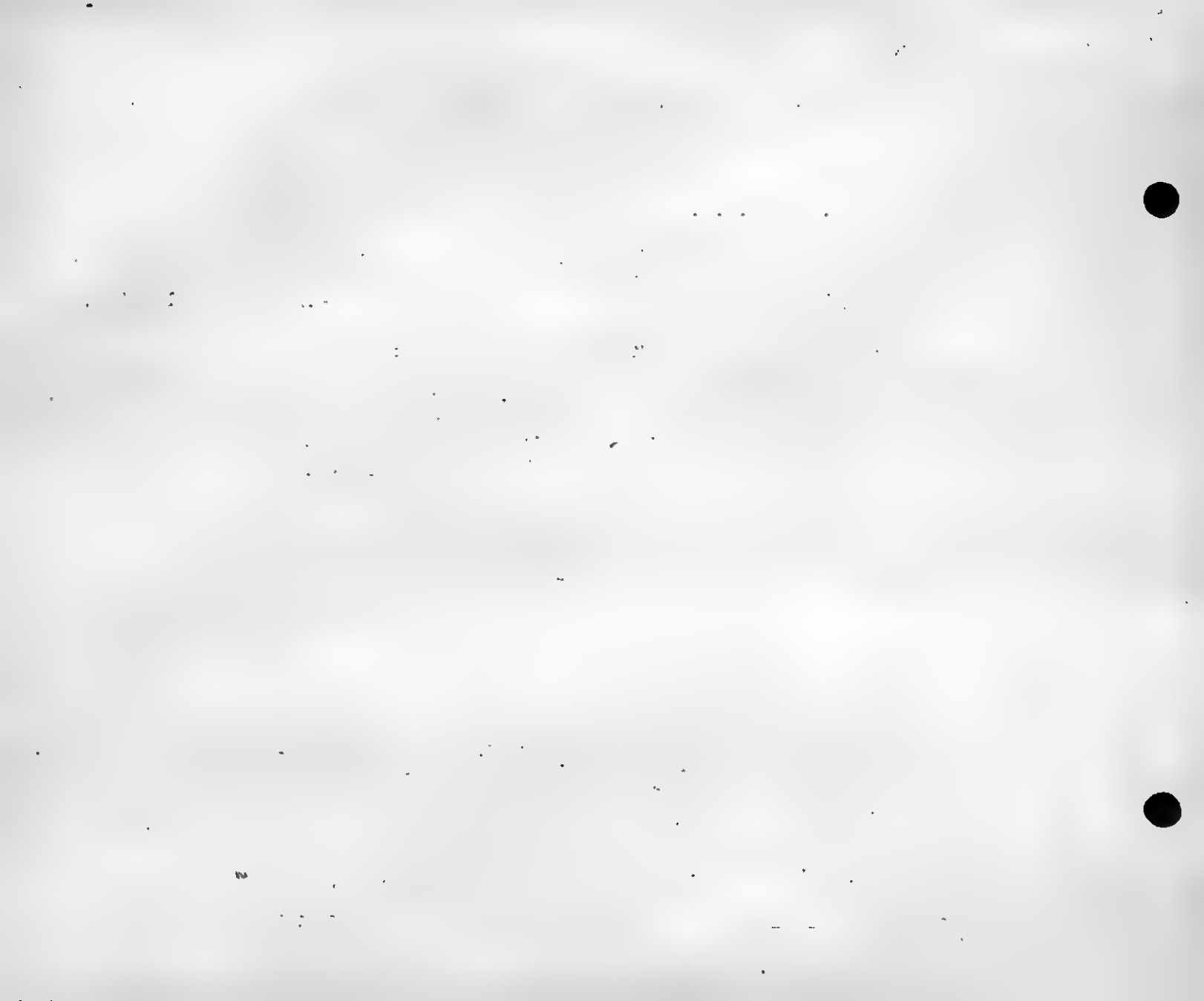
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05181

05173

1 DECEASED NAME (Type or print) LOUIS STANFORD SCHLOSS			2a. DATE OF DEATH Month APRIL Day 19 Year 1969			2b. HOUR 1:30 P.M.			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH 12-1-1916		6. AGE (in years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH BALTIMORE Md.			
10 CITY OR TOWN OF DEATH BALTIMORE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KEYSER & TOPPING ROADS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY SURPLUS			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN KEYSER & TOPPING RDS.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME First Middle Last MOSES SCHLOSS			15 MOTHER'S MAIDEN NAME First Middle Last SOPHIA ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. NO		17. INFORMANT Address MRS. MURIAL SCHLOSS, KEYSER & TOPPING RDS.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon metastatic to liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO, OR AS A CONSEQUENCE OF (c) None								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1968 , to April 19, 1969 , that (I) (we) lost the deceased alive on April 19, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Manuel Levin		22c. DATE SIGNED 4/19/69		22d. PHYSICIAN'S NAME (Type) MANUEL LEVIN, M.D.		22e. ADDRESS 1101 PARK HILLS AVE, BALTO-15 MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-21-69		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION (City or Town) (County) (State) REISTERSTOWN, MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05182

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05174

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR		
SIDNEY				SCHLOSS	APRIL 30, 1969		9 A.M.		
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE	WHITE		APRIL 3, 1913		56 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
BALTIMORE, MD.		U.S.A.				BALTIMORE Md			
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		3215 MIDFIELD ROAD		PROPRIETOR DELICATESSEN STORE					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		BALTIMORE						3215 MIDFIELD ROAD	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
DAVID				SCHLOSS	SARAH				?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT			Address
NO						MRS. FANNIE SCHLOSS,			3215 MIDFIELD ROAD #8
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>412.3</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Repet myocardial infarctions</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>14-5 yrs</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Retention test Sarcoma</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>April 30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-30</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Joseph C. Matchar MD</u>				22c. DATE SIGNED <u>4/30/69</u>					
22d. PHYSICIAN'S NAME (Type) JOSEPH C. MATCHAR				22e. ADDRESS 6821 REISTERSTOWN ROAD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		5-1-69		SHAAREI TFILOH		BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05183		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05175	
1 DECEASED NAME (Type or print) First Middle Last		2a DATE OF DEATH Month Day Year		2b. HOUR			
Samuel A. Schmidt		April 15, 1969		M			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday) YRS.	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS. HOURS MIN		
Male	Caucasian	October 15, 1887	81				
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH				
Maryland	U.S.A.		Baltimore Md.				
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY				
Randallstown	Liberty & Robeson Roads	Owner	Retail Auto				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INS DE CITY, AT 15? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER			
Maryland	Baltimore	Randallstown		9105 Liberty Road			
14 FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last						
Henry Schmidt	Elizabeth Kennell						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17 INFORMANT	Address				
No	212-16-4045	Virginia D. Mettam	9105 Liberty Road				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia Aspiration</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>PVA & Hemiplegia</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular Arteriosclerosis</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from <u>2-22-1964</u> , to <u>4-14-1969</u> , that (I) (we) last saw the deceased alive on <u>4-14-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED			
Dr. Cesar Cavero							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Dr. Cesar Cavero		8629 Liberty Road					
23a B. BURIAL, CREMATION OR REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial	4/18/69	Mt. Olive Cemetery		Randallstown Baltimore Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Loring Byers Chapel		8728 Liberty Road 21133		APR 21 1969	Charles J. Judd		

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1

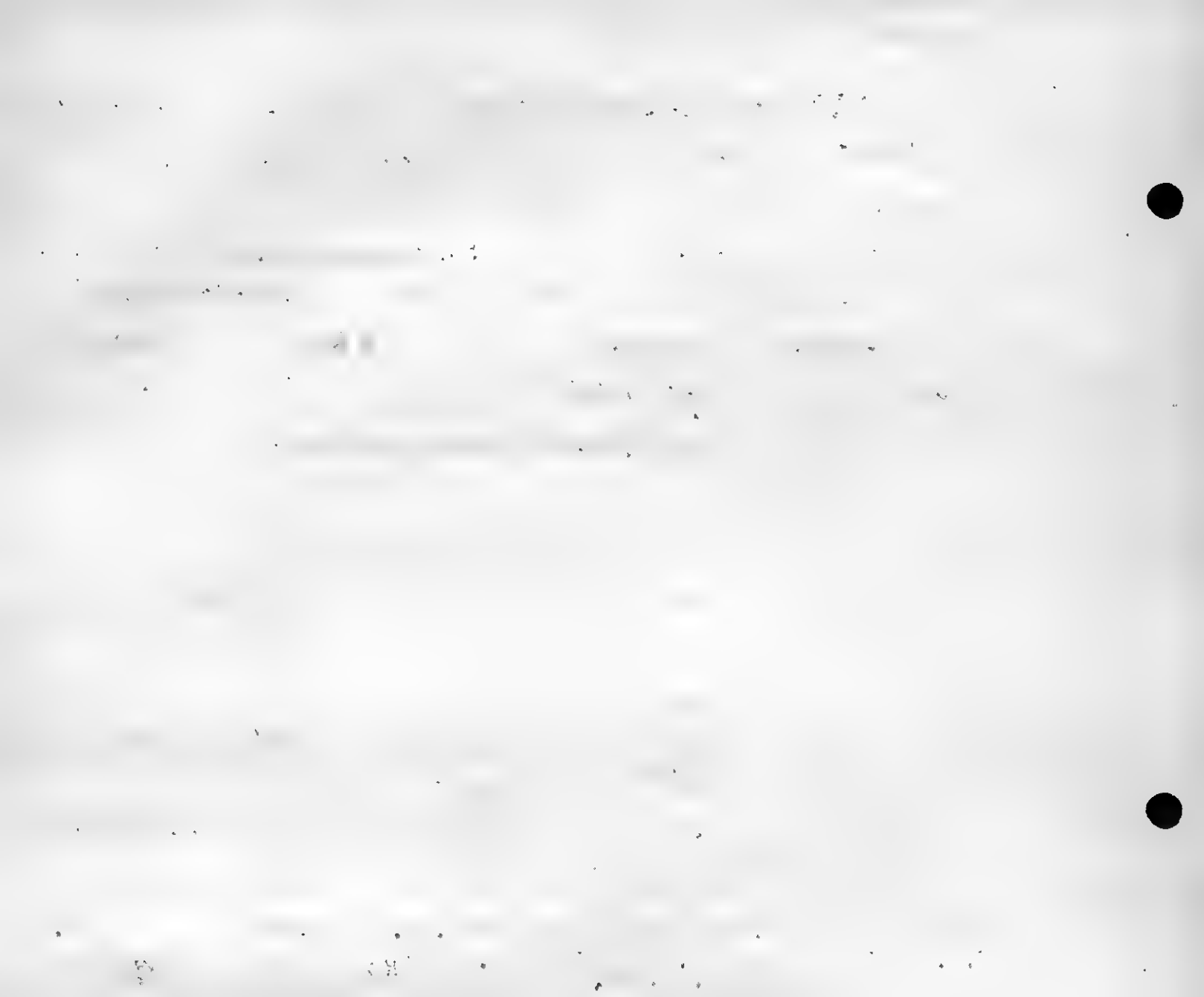
05184

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05176

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) CLARENCE OSCAR SCHOOL			2a DATE OF DEATH Month April Day 22 Year 1969			2b HOUR 11:15 AM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 4/13/02		6 AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County			
10 CITY OR TOWN OF DEATH Mount Wilson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hospital		12a USUAL OCCUPATION (Kind of work done during most of last year; retired) RETIRED CLERK - U.S. GOVT		12b KIND OF BUSINESS OR INDUSTRY GOVT ADMIN.			
13a USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE MD.		13b COUNTY BALTIMORE		13c CITY OR TOWN BALTIMORE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1238 GLEN HAVEN RD.	
14 FATHER'S NAME First Middle Last WILLIAM SCHOOL			15. MOTHER'S MAIDEN NAME First Middle Last MARY BROOKS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b SOCIAL SECURITY NO 218-07-0761		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) For Advanced Pulmonary Tuberculosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that the (this hospital) attended the deceased from 21 Mar 1969 to 22 Apr 1969 , that we (we) lost the deceased alive on 22 April 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, the (we) (did) (did not) view the body after death.									
22b. SIGNATURE William Newcomer		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 22 April 1969					
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.		22e. ADDRESS Mount Wilson, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/25/1969		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION (City or Town) (County) (State) Dorsey Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE APR 23 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

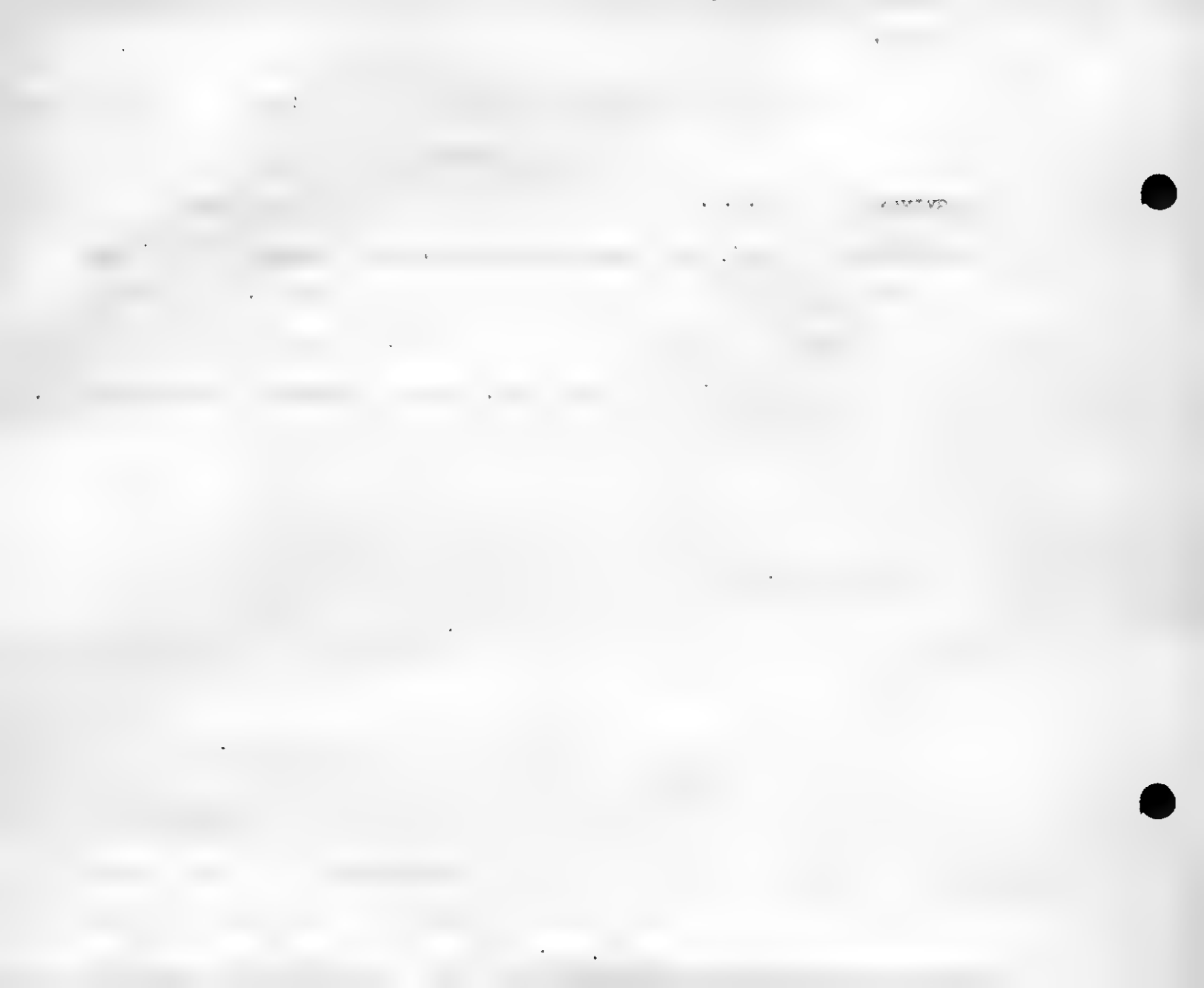


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VR A15
45M - 1/69

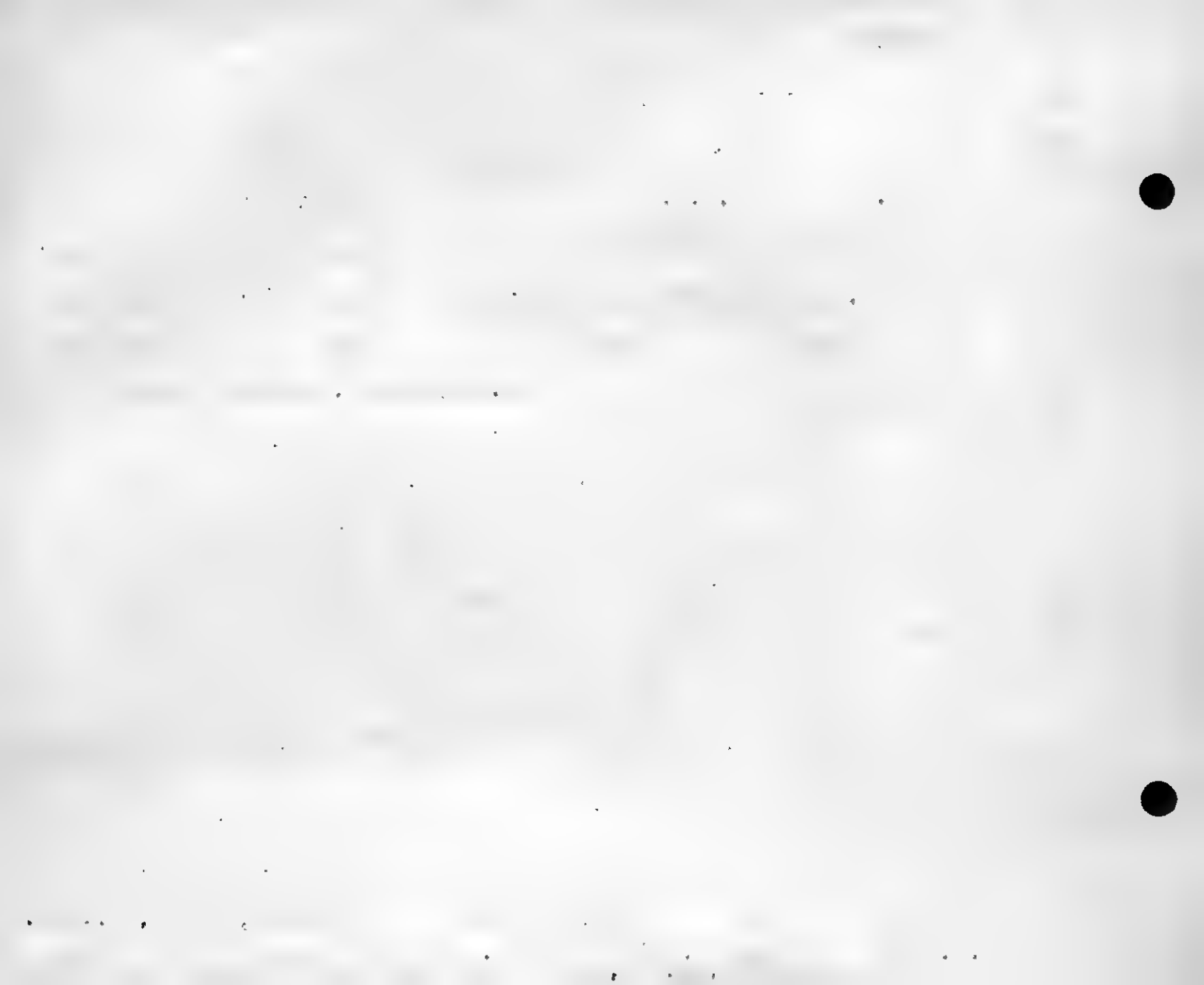
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First Middle Last			20. DATE OF DEATH			2b. HOUR			
JOSEPH EDWARD SCHOLTES						APRIL Month 25 Day 1969 Year			9:20 PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Male		White		3/19/96		73 YRS						
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH						
PENNSYLVANIA		U.S.A.				BALTIMORE			Md.			
1d CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
FORT HOWARD		VETERANS ADMINISTRATION HOSPITAL				Walter			SEA FOOD			
13a U.S.A. RESIDENCE (Where deceased lived, if not in hospital residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY, TOWN OR VILLAGE? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND						BALTIMORE				642 E. Fort Avenue		
14 FATHER'S NAME			First Middle Last			15 MOTHER'S M A DEN NAME			First Middle Last			
PETER SCHOLTES						ELIZABETH GABLE						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
YES WW I			186 01 01 44			Clin. Records, VA Hospital, Fort Howard, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA										DAYS		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
SEVERE ARTERIOSCLEROSIS												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION		Street or R.F.D. No.		City or Town		County State		
22a I certify that (X) (this hospital) attended the deceased from April 1, 1969, to April 25, 1969, that (X) (we) last saw the deceased alive on April 25, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.												
22b SIGNATURE						DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED		
PHILIP M. Ashman MD										4/26/69		
22d PHYSICIAN'S NAME (Type)						22e ADDRESS						
PHILIP M. ASHMAN, M.D.						VA HOSPITAL, FORT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)		
Burial		4/29/69		New Cathedral Cemetery		Baltimore, Maryland						
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				130 E. Fort Avenue				APR 29 1969		McGully Funeral Home		
				Baltimore, Maryland								



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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or print)			First CORDELIA			Middle S.			Last SCHULZ			2a. DATE OF DEATH 04 Month 30 Day 69			2b. HOUR 11:12 PM		
3 SEX FEMALE			4 RACE CAU			5. DATE OF BIRTH 1-12-90			6. AGE (in years last birthday) 79 YRS.			7 UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH BALTIMORE			Md.					
10. CITY OR TOWN OF DEATH TOWSON, MARYLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GTRR. BALTO. MED. CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Ruxton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2 WineSpring Garth					
14. FATHER'S NAME John			First John			Middle Stokes			15. MOTHER'S MAIDEN NAME Mary			First Mary			Middle Ziegler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT Mrs. Benjamin E. Beavin			Address (Same)					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>VENTRICULAR TACHYARRHYTHMIA & PUL. EDEMA</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDIO VASULAR DISEASE</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CH. C.H.F.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State 10-30 PM 11:12 PM											
22a. I certify that (I) (this hospital) attended the deceased from 4-30, 19 69, to 4-30, 19 69, that (I) (we) last saw the deceased alive on 11:12 PM 4-30 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Dost Mohammad MD			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 05-01-69								
22d. PHYSICIAN'S NAME (Type) DOST MOHAMMAD MD			22e. ADDRESS 6701 NORTH CHARLES STREET														
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment			23b. DATE 5/3/69			23c. NAME OF CEMETERY OR CREMATORY Lorraine Park			23d. LOCATION (City or Town) (County) (State) Woodlawn, Balto. Co., Md.								
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.			ADDRESS 4905 York Rd. Balto. 12, Md.			25a. REC'D BY REGISTRAR DATE MAY 1 1969			25b. REGISTRAR'S SIGNATURE Charles Judge								



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15/14
30M REV 11-68

05187

05179

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) aka (ROBERT HENRY Middle SCHULZ) HENRY SCHULZE		2a DATE OF DEATH April Month 28 Day 1969		2b HOUR 7 P.M
3 SEX Male	4. RACE White	5 DATE OF BIRTH July 17, 1897	6 AGE (In years last birthday) 71 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Baltimore County, Md.	
10 CITY OR TOWN OF DEATH Catonsville	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 200 Huron Rd.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) commercial artist	12b. KIND OF BUSINESS OR INDUSTRY retired	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b COUNTY Baltimore	13c CITY OR TOWN Ctnsvll.	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 200 Huron Road -21228
14 FATHER'S NAME First Herman Middle Schulze Last Schulze	15. MOTHER'S MAIDEN NAME First Caroline Middle Rohrman Last Rohrman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) yes (If yes give war and dates of service) WW I	16b SOCIAL SECURITY NO 216-32-3846B	17 INFORMANT Address Mrs. Lillian E. Schulze 200 Huron Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621 bronchiogenic carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Aug , 19 68 , to April , 19 69 , that (I) (we) last saw the deceased alive on 5/8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Edgar P. Williamson M.D.		DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 4-30-69
22d. PHYSICIAN'S NAME (Type) Edgar P. Williamson		22e. ADDRESS 5550 Balto. National Pike		
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE May 2, 1969	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR ADDRESS H. Sander & Sons, Inc., Balto., Md.		25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05188

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05180

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <u>Samuel</u> <u>Schumick</u>			2a. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1969</u>			2b. HOUR <u>2 P.</u> M.					
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>July 4, 1898</u>		6. AGE (In years last birthday) <u>70</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>		IF UNDER 24 HRS HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md.					
10. CITY OR TOWN OF DEATH <u>Baltimore</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>3209 Mayfair Rd</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Retail</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <u>Maryland</u>			13b. COUNTY <u>Baltimore</u>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET AND NUMBER <u>3209 Mayfair Rd</u>		
14. FATHER'S NAME First <u>Isadore</u> Middle <u>Schumick</u> Last <u>Schumick</u>			15. MOTHER'S MAIDEN NAME First <u>Ethel</u> Middle <u> </u> Last <u> </u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>No</u> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT <u>Norman Schumick - 3209 Mayfair Rd</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>18 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>1969</u> P.M. <u> </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/9</u> , 19 <u>67</u> , to <u>4/2</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Isidor</u> MD DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>4/3/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>ISIDOR H. BERG</u>				22e. ADDRESS <u>4000 W. Northern Parkway</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>April 6/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Tylach</u>				23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Md.</u>			
24. FUNERAL DIRECTOR <u>Sal Simon & Sons</u>				ADDRESS <u>6010 Rust Rd</u>				25a. REC'D BY REGISTRAR <u>APR 9 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. ...</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05189

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05181

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year			2b HOJR						
IDA			ROSA			SHETTLE			April 27, 1969 6:15A						
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN					
Female		White		Nov. 27, 1948		20 ? YRS.									
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Maryland			USA						Baltimore Md.						
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b KIND OF BUSINESS OR INDUSTRY			
Parkville				Putty Hill & Fern Avenue				Machine Operator							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Maryland				Balto.		Parkville				2517 Glenco Rd.					
14 FATHER'S NAME			First Middle Last			15 MOTHER'S MAIDEN NAME			First Middle Last						
George E. Orwig						Elizabeth R. McLew									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			217-50-4889			Kenneth G. Shettle			(Same)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio cerebral Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 5:45 AM 4-27- 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Passenger, in auto struck utility pole							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street				21f. LOCATION Street or R.F.D. No City or Town County State Putty Hill & Fern Ave. Parkville Balto. M.D.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				4/27/69							
Ronald N. Kornblum, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)							
23a. B. RIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				4/30/69				Moreland Memorial				Baltimore Maryland			
24. FUNERAL DIRECTOR						ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck Inc. 5305 Harford Road 21214												APR 29 1969		J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 68

05190

CERTIFICATE OF DEATH

05182

1. DECEASED-NAME (Type or print) Erman			First A Middle Last Shoemaker			2a. DATE OF DEATH Month 4 Day 23 Year 69			2b. HOUR 1:43 PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH JAN. 21, 1887			6. AGE (In years last birthday) 82 YRS.		
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore		
10. CITY OR TOWN OF DEATH RANDALLSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Conv.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER			12b. KIND OF BUSINESS OR INDUSTRY FARM		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MD.			13b. COUNTY Carroll			13c. CITY OR TOWN WESTMINSTER			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER GREEN STREET			14. FATHER'S NAME DAVID M. SHOEMAKER			15. MOTHER'S MAIDEN NAME MARY - BLACK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. ?			17. INFORMANT MRS. NORMAN HULL			Address WESTMINSTER, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Thrombosis, A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF (b) C.A.S. stroke & Thrombosis, med DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Brain Syndrome, Cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH to 4-23-69	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) TURP prostate											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-23-69 , to 4-23-69 , that (I) (we) last saw the deceased alive on 4-23-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Howard E. Hall, M.D.						DEGREE MD ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-23-69		
22d. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.						22e. ADDRESS College Ave. Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-26-69			23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery			23d. LOCATION (City or Town) (County) (State) Sykesville, Md.		
24. FUNERAL DIRECTOR Harry W. Haight						ADDRESS Sykesville, Md.			25a. REC'D BY REGISTRAR APR 29 1969		
						25b. REGISTRAR'S SIGNATURE Thomas J. Young					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

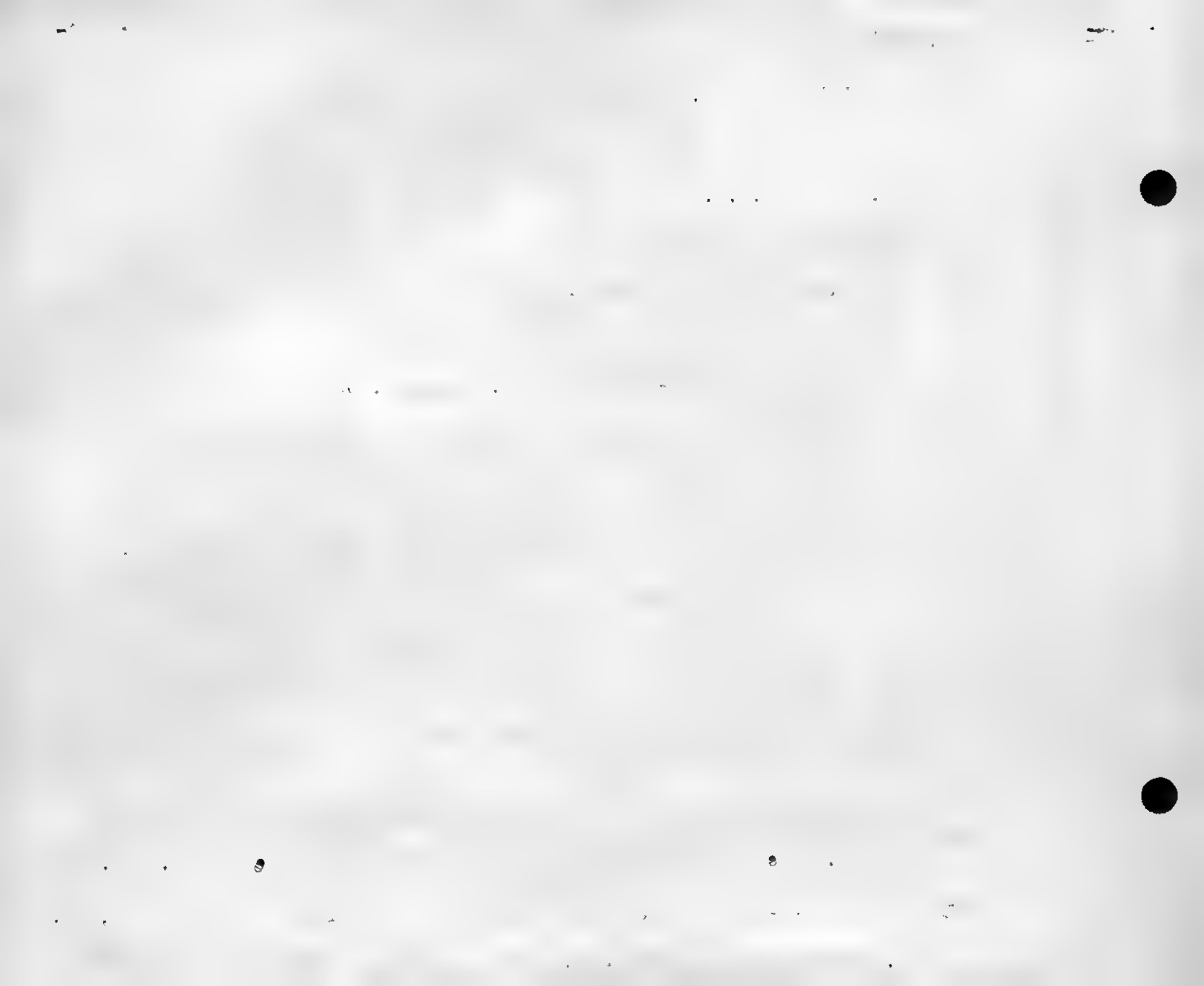
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05191											
CERTIFICATE OF DEATH											
05183											
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH Month Day Year		2b HOUR	
WILLIAM						SHRIVER		APRIL 30, 1969		8:10 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
MALE		CAUCASIAN		MARCH 10, 1897		72 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD		HOSPITAL VETERANS ADMINISTRATION		FARMER		Self-Employed					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
MARYLAND		DORCHESTER		CAMBRIDGE				R.F.D. # 3			
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
HENRY		A		SHRIVER				ANNA		COMSTOCK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address					
YES		WWII		216 56 1278		CLINICAL RECORDS, VA HOSPITAL, FT HOWARD, MD					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MILIARY TUBERCULOSIS LUNGS, BILATERAL											
0114 DUE TO, OR AS A CONSEQUENCE OF BRONCHOPNEUMONIA											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
RHEUMATOID ARTHRITIS, MARKED											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21c LOCATION Street or R.F.D. No. City or Town County State							
22a I certify that XXXXX (hospital) attended the deceased from 4/26/69, 19, to 4/30/69, 19, that XX (we) last saw the deceased alive on 4/30/69, 19, and that XXXXX (hour) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (did not) view the body after death											
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e ADDRESS					
ERHARD J. BUNYOR, M.D.		4/30/69		VA HOSPITAL, FORT HOWARD, MD							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
BURIAL		May 5, 1969		BALTO NATIONAL CEMETERY		BALTIMORE, MD					
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
Singleton Funeral Home, 2nd ave SW, Glen		MAY 5 1969									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05192										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05183									
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
MYRTLE F. SHROM										April Month 6, 1969 Year										M									
3. SEX										4 RACE										5. DATE OF BIRTH									
Female										White										April 1, 1883									
7a BIRTHPLACE (State or foreign country)										7b CITIZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
Penna.										U.S.A.										Baltimore									
10. CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)									
Arbutus										1030 Elm Road										Housewife									
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE										13b COUNTY										13c CITY OR TOWN									
Maryland										Baltimore										Arbutus									
14. FATHER'S NAME										15 MOTHER'S MAIDEN NAME										16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)									
Unknown										Unknown										No									
16b SOCIAL SECURITY NO										17 INFORMANT										18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4124									
190-09-2362										Mrs. Robert B. Grayson, 1030 Elm Road 21227										Cardiovascular Disease									
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?									
																				YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)									
										Hour A.M. Month Day Year P.M. 19																			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)										21f LOCATION									
																				Street or R.F.D. No City or Town County State									
22a I certify that (I) (this hospital) attended the deceased from July 1967, 19 to 4/6, 1969, that (I) (we) last saw the deceased alive on 4/6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE										22c. DATE SIGNED										22d PHYSICIAN'S NAME (Type)									
Dr. James N. Frederick										4/7/69										Dr. James N. Frederick									
22e ADDRESS										23a BURLIAL, CREMATION, OR OTHER (Specify)										23b DATE									
1311 Francis Avenue, Balto., Md. 21227										BURIAL										4-9-1969									
23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)										24 FUNERAL DIRECTOR									
Meadowridge Cemetery										Dorsey, Howard County, Md.										Howard H. Hubbard, 4107 Wilkens Ave. 21229									
25a REC'D BY REGISTRAR										25b REGISTRAR'S SIGNATURE										25c. DATE									
APR 9 1969										Charles Judge										APR 9 1969									

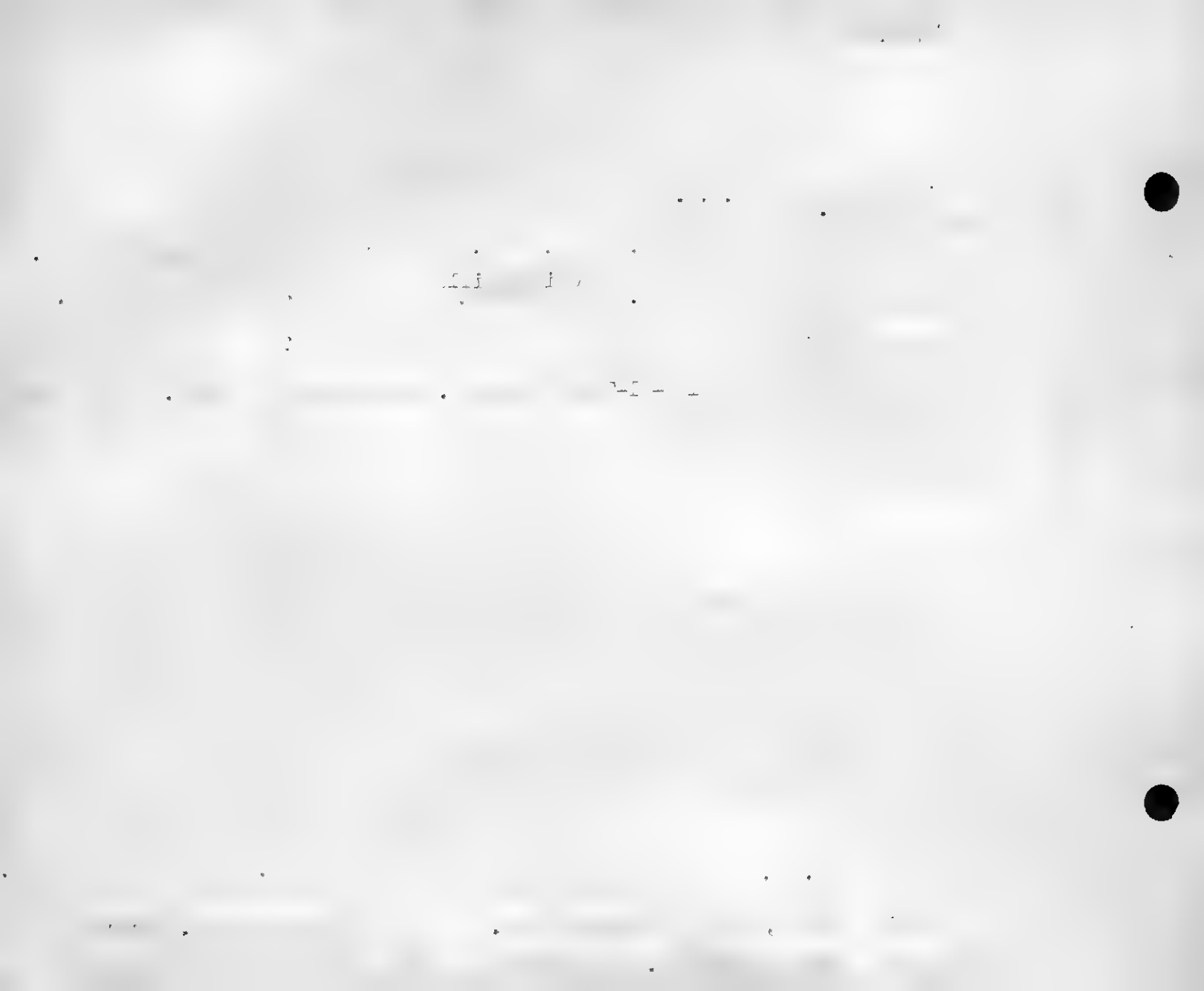


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05193		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05185	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First Lewis	Middle NMI	Last Siperko	2a. DATE OF DEATH Month Day Year April 30 69
3. SEX Male		4. RACE white		5. DATE OF BIRTH 12/2/97	2b. HOUR 5:45 PM
7a. BIRTHPLACE (State or foreign country) Wilkes Barre PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6. AGE (In years last birthday) 71 YRS.
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Cnty. Gen.		9. COUNTY OF DEATH Baltimore Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Balto.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Merchant Univer sal Machine Co.	
14. FATHER'S NAME Matthew Siperko		15. MOTHER'S MAIDEN NAME Mary ?		13c. STREET AND NUMBER Rte. 2 Deer Park Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) NO		16b. SOCIAL SECURITY NO. 189-01-7029		17. INFORMANT Linnea R. Siperko Deer Park Rd., Owings Mills	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Extensive and Massive Pulmonary Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Kaposi's Sarcoma</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Dr. C. Caverio</i> MD				22c. DATE SIGNED 4.30.69	
22d. PHYSICIAN'S NAME (Type) Dr. C. Caverio				22e. ADDRESS 8629 Liberty Rd., Randallstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 3, 69		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	
24. FUNERAL DIRECTOR Loring Byers		23d. LOCATION (City or Town) (County) (State) Glen Burnie Md. Annapundal		25a. REC'D BY REGISTRAR DATE MAY 5 1969	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05194

CERTIFICATE OF DEATH

05186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Sudbrook Crt., Pikesville, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Miriam Slesinger First Middle Last Bechhofer Slesinger		4. DATE OF DEATH Month April Day 5 Year 1969	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1885
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Mm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Slesinger	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Bechhofer		14. MOTHER'S MAIDEN NAME Rebecca Straus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. 218-01-0055	
17. INFORMANT Mrs. Alice S. Eigenbrun		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 436.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes with gangrene of left foot			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from January, 1969 to 4/5 , 1969, that I last saw the deceased alive on 4/1 , 1969, and that death occurred at 4:20 P M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Louis H. Schaffer		ADDRESS (Street, city or town, state) 272 W Cold Spring Lane, Balto, Md	
PHYSICIAN'S NAME (Type) LOUIS H. SCHAFER, M.D.		DATE SIGNED 4/7/69	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF April 9, 1969	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR APR 9 1969	
ADDRESS Pikesville 8, Md.		24b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 will be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05187										
1. DECEASED-NAME (Type or Print) First Middle Last Susan E. Small						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year ESTIMATED <input type="checkbox"/> Apr. 16 1969		2b. HOUR 10:15 P.M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH 4-13-1877	6. AGE (In years last birthday) 92 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year Apr. 16 1969		2d. HOUR		
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.				
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chapel Hill Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) at home		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5511 Gwynn Oak Avenue 7	
14. FATHER'S NAME First Middle Last Charles Emich			15. MOTHER'S MAIDEN NAME First Middle Last Fulton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give year or dates of service) No		17. INFORMANT ADDRESS William R. Small-R. D. L-Holtwood, Pa. 17532					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 da. 2 wks. 5 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Fracture of rt. hip- Decubitus ulcers, extensive.</u>										
19a. DATE OF OPERATION Mar. 9, 1969			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured hip				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 5:15 P.M. Mar. 8 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) slipped off comode in room and fractured hip.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Chapel Hill Nurs. Home		21f. LOCATION Street or R.F.D. No City or Town County State Randallstown Balto. Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE D. D. Caples		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4-18-69		
EXAMINER'S NAME (Type) D. D. Caples, M. D., 6 Hanover Rd., Reisterstown, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-19-69		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR ADDRESS Armancost Funeral Chapel-4600 Liberty Hts.				25a. RECD BY REGISTRAR APR 22 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 days after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05196		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05188			
1. DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year		2b. HOUR	
MARY A. Smith						4 12 69		950 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female		White		5-14-1880		88 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Garrison, Md.		Foxleigh Nurs. Hm.		homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Balto.						624 Dunkirk Road	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
Smith, A. George		Catherine Moylan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no		220-30-2638		Nellie M. Patterson 606 B Walker Ave. #21212					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction								hours	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) stating the underlying cause last. (b) Arteriosclerosis								years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1969, to April 12, 1969, that (I) (we) last saw the deceased alive on April 12, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
David J. Miller						April 12-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
David J. Miller		2215 Roisterdown Rd. Owings							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/15/69		Cathedral Cemetery		Balto., Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE			
Mitchell-Wiedefeld Home 6500 York Rd. Balto. Md. 21212				APR 18 1969		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05197

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05189

1. DECEASED-NAME (Type or print)			First WILLIAM	Middle TAYLOR	Last SMITH	2a. DATE OF DEATH April Month 7, 1969 Year			2b. HOUR M		
3 SEX Male		4 RACE White		5. DATE OF BIRTH 11-17-1913		6 AGE (in years last birthday) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore			Ma		
10 CITY OR TOWN OF DEATH Edmondson Heights		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1147 Granville Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Banker		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edmondson Heights		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1147 Granville Road			
14. FATHER'S NAME			First Joseph Roane	Middle Smith, Jr.	Last	15. MOTHER'S MAIDEN NAME			First Ethel R.	Middle Taylor	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		(If yes give year or dates of service) WW II		16b. SOCIAL SECURITY NO. 217-03-7934		17. INFORMANT Mrs. Helen K. Smith, 1147 Granville Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Previous Myocardial Infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>4/7</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>June</u> 19 <u>65</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.											
22b. SIGNATURE <u>James Nolan</u>		DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>4/8/69</u>					
22d. PHYSICIAN'S NAME (Type) Dr. James Nolan		22e. ADDRESS 1 Mallow Hill Road, Balto., Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-10-1969		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) Pikesville, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS		25a. RECEIVED BY REGISTRAR APR 9 1969		25b. REGISTRAR'S SIGNATURE <u>John A. Jones</u>					

James M. McLaughlin
Corner 10th & 11th
Sts. N. W.

11-22

05198

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) WARREN A. Spilman			2a. DATE OF DEATH Month April Day 6 Year 1969			2b. HOUR 10 P.M.	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 11-30-1903		6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) BALTO.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE	
10. CITY OR TOWN OF DEATH BANDALLSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO Co. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cy P Telephone		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 6100 WINDSOR MILL Rd		14. FATHER'S NAME First Robert E. Spilman Middle L. Last Spilman		15. MOTHER'S MAIDEN NAME First Julie Middle Provost Last Provost			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown No		16b. SOCIAL SECURITY NO 577-01-9143		17. INFORMANT HAZEL R. Spilman - Same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2/17 , 19 44 , to 4/6 , 19 69 , that (I) (we) last saw the deceased alive on 3/31 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE Robert A. Reiter, M.D.				DEGREE M.D.		22c. DATE SIGNED 4/7/69	
22d. PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D.				22e. ADDRESS 606 Edmondson Ave, 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-10-69		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) (County) (State) BALTO Md	
24. FUNERAL DIRECTOR Armcast Funeral Chapel		ADDRESS 4600 Lib. Hgts Ave		25a. RECD BY REGISTRAR APR 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
45M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05199									
05191									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			P. HOUR P. 25 M
Luther			Stallings			April 4, 1969			
3 SEX male		4. RACE white		5. DATE OF BIRTH 1905		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
						63 YRS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore Md			
Md.		U. S.							
10 CITY OR TOWN OF DEATH Catonsville			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING GROVE STATE HOSP.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) laborer		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Md.			Calvert		St. Leonard		YES <input type="checkbox"/> NO <input type="checkbox"/>		none
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
William			Katie						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Recent bacterial pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I (this hospital) attended the deceased from <u>June 19, 1950</u> to <u>April 4, 1969</u> , that I (we) last saw the deceased alive on <u>April 4, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did not) view the body after death.									
22b. SIGNATURE <u>Rafael H. Marin</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>4-7-69</u>		
22d. PHYSICIAN'S NAME (Type) Rafael H. Marin, M.D.					22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Buried April 11 1969</u>		<u>April 11 1969</u>		<u>New Cathedral</u>		<u>Old Federal Road Baltimore Md</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Kramer Funeral Home 1216 S Charles St</u>					25a. REC'D BY REGISTRAR DATE <u>APR 14 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

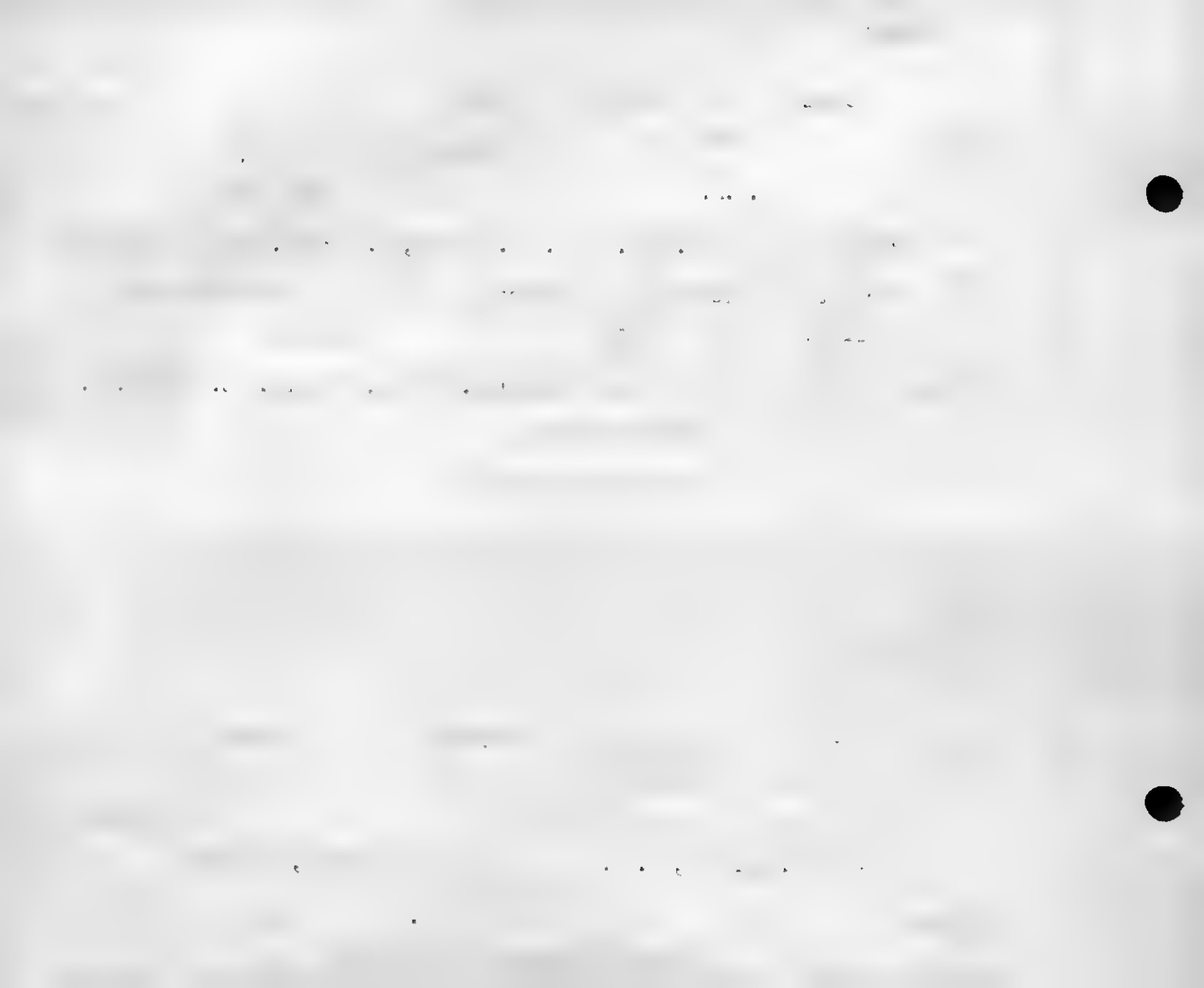
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05200 Item 8 Film 113 5/29/69 kk									
05192									
1 DECEASED NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR		
Emmet E. Stevens					April 21 st 1969		Year		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
M		W		3-23-1910		39 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U. S. A.				Baltimore			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. US. JA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Towson		St. Joseph Hospital		Carpenter					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 157		3e. STREET AND NUMBER	
Maryland				Kingsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		629 New Cut Road	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Allie B. Stevens			Annie M. Bell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT Address					
WWII		216-10-0294		Mrs. Michael Raab 3102 Batavia Ave. 21214					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion - 2 1/2 hrs.</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21a. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from <u>6/30/61</u> , 19 <u> </u> to <u>4/21/69</u> 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>4/21/69</u> 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<u>Theodore E. Evans M.D.</u>								4/22/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Theodore E. Evans, M.D.				Perry Hall Medical Center 9660 Belair Rd					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		4-24-69		Green Lawn Cemetery		Bowling Green, Virginia			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard 4107 Wilkens Ave. 21229						APR 24 1969		<u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05201										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05193																													
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last										Month Day Year										Hour																													
CHARLES ALBERT STEWART										4 30 69										6:30A M																													
3 SEX MALE										4 RACE WHITE										5 DATE OF BIRTH 2/20/98										6 AGE (In years last birthday) 71 YRS.										7 UNDER 24 HRS MONTHS DAYS HOURS MIN									
7a BIRTHPLACE (State or foreign country) Maine										7b CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Baltimore Md																			
10 CITY OR TOWN OF DEATH Fort Howard										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Vet. Adm. Hosp. Ft. Howard, Md.										12a USUA. OCCUPATION (Kind of work done during most of last year, or retired) Maint. Man										12b KIND OF BUSINESS OR INDUSTRY Hospital																			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Virginia										13b COUNTY Occamack										13c CITY OR TOWN Onancock										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 31 Aimes Street									
14 FATHER'S NAME First Middle Last William Stewart										15 MOTHER'S MA DEN NAME First Middle Last Jeanette																																							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes										(If yes give war or dates of service) WW I										16b SOCIAL SECURITY NO 218 18 33 82										17 INFORMANT Address Clin. Records, Va Hosp. Ft. Howard, Md.																			
18 CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 492x										DUE TO, OR AS A CONSEQUENCE OF (b) OBSTRUCTIVE EMPHYSEMA										DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																	
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.										21f. LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (X) (this hospital) attended the deceased from 3/22/69, 19, to 4/30/69, 19, that (I) (we) last saw the deceased alive on 4/30/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										22b. SIGNATURE John D. Talbert, M.D.										22c. DATE SIGNED 4/30/69																													
22d. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.										22e. ADDRESS VAH FT HOWARD, MARYLAND																																							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b DATE 5/3/69										23c NAME OF CEMETERY OR CREMATORY Fairview Lawn Cem.										23d LOCATED IN (City or Town) Onancock (County) accomack (State) Va																			
24 FUNERAL DIRECTOR Severn Park, Robert S. Benavides M.D.										25a ADDRESS CARLISLE WILLIAMS FUNERAL HOME, ONANCOCK, VIRGINIA										25b REC'D BY REGISTRAR DATE 4/30/69										25c REGISTRAR'S SIGNATURE Charles Judge																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) LOUISE CAROLINE LIZETTE STISSEL					2a DATE OF DEATH Month April Day 8 Year 1969			2b HOUR 4:30 AM	
3. SEX Female		4. RACE White		5 DATE OF BIRTH March 31, 1879		6 AGE (In years last birthday) 90 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN 	
7a BIRTHPLACE (State or foreign country) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.			
10. CITY OR TOWN OF DEATH Towson		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney-Towson Nurs.Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland		13b COUNTY 		13c CITY OR TOWN Balto.City		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1823 East 31st. Street	
14. FATHER'S NAME First Wilhelm Middle Last Hundertmark			15. MOTHER'S MAIDEN NAME First Julia Middle Last Grohne						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b SOCIAL SECURITY NO 220-44-8228		17 INFORMANT Carl F. Stissel		Address 2445 Pickwick Rd., Balto. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) Pulmonary edema. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 10 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State 					
22a. I certify that (I) (the hospital) attended the deceased from Apr. 7, 1969 to 4/8, 1969 , that (I) (we) lost saw the deceased alive on Apr 7, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Norman R. Freeman DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c DATE SIGNED 4/9/69					
22d. PHYSICIAN'S NAME (Type) NORMAN R. FREEMAN				22e ADDRESS 11 W. 25th ST.					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE Aprl. 10, 69		23c NAME OF CEMETERY OR CREMATORY PARKWOOD		23d LOCATION (City or Town) Taylor Av., Parkville, Balto. (County) (State) 			
24 FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av., City 1				25a REC'D BY REGISTRAR APR 11 1969		25b REGISTRAR'S SIGNATURE Charles J. J...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove or ban papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05195

1 DECEASED-NAME (Type or print)			First MILTON	Middle VICTOR	Last STRASBURGER	2a. DATE OF DEATH Month 25, Day 1969 Year			2b. HOUR 7 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH		6. AGE (In years last birthday) 96 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) WESTMINSTER, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CHAPEL HILL NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3301 DORITAN ROAD		
14. FATHER'S NAME First VICTOR Middle C. Last STRASBURGER			15. MOTHER'S MAIDEN NAME First SALLIE Middle STEIN Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 215-22-6003		17 INFORMANT MR. LEROY STRASBURGER		Address 3800 MENLO DRIVE				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell C.A. of mouth 1459 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastases to mouth and Neck DUE TO, OR AS A CONSEQUENCE OF (c) mandible and lymphatics										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 2-5-1969 to 4-25-1969, that (I) (we) last saw the deceased alive on 4-25-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Cesar Valle Cervero				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-25-69				
22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO				22e. ADDRESS 8629 LIBERTY ROAD						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-27-69		23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		23d. LOCATION (City or Town) BALTIMORE, MARYLAND		(County) (State)		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05204

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05196

1 DECEASED NAME (Type or Print) HENRY H. SULLIVAN			2a DATE KNOWN OF EST- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 1969 11/4		
3 SEX Male	4 RACE White	5. DATE OF BIRTH Aug. 3, 1910	6 AGE (In years last birthday) 58 YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Baltimore
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6905 Dunmanway		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Blocker, Wire Mill	
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 14 Admiral Blvd.
14. FATHER'S NAME First James Middle S. Last Sullivan			15. MOTHER'S MAIDEN NAME First Lulu Middle Turner Last Turner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO 223-20-4749		17 INFORMANT Thomas C. Sullivan	
				ADDRESS 14, Admiral Blvd. 21222	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) ACVD DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Theodore C. Patterson		M.D. Theodore C. Patterson, M.D.		22b. DATE SIGNED 4/11/69	
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county) 3427 Dundalk Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Apr. 12, 1969	23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		23d. LOCATION (City or Town) (County) (State) Dorsey, Md.	
24. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.			ADDRESS		25a. REC'D BY REGISTRAR APR 14 1969
					25b. REGISTRAR'S SIGNATURE Richard S. Jones

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05205 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05197	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Stanley		Middle Szczech		Last Szczech		2a DATE KNOWN OF DEATH ESTIMATED 4-28-69		2b HOUR 5:20
3 SEX Male	4 RACE White	5 DATE OF BIRTH Aug. 12, 1906		6 AGE (in years and birthday) 62 YRS.	7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD April 28 1969		2d HOUR 7:30
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore				
10. CITY OR TOWN OF DEATH Fort Howard			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Box 199 Route 10				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farm work			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admiss on) STATE Maryland			13b COUNTY Baltimore		13c CITY OR TOWN Ft. Howard		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER Box 199 Route 10		
14 FATHER'S NAME First Andrew			Middle Szczechowiak		Last Szczechowiak		15 MOTHER'S MAIDEN NAME First Frances			Middle Teclaw	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			(If yes give war or dates of service)		16b SOCIAL SECURITY NO. 213-07-9296		17. INFORMANT Brother Joseph Szczech			ADDRESS Ft. Howard, Md. Box 199 Route #10	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/24 A-S-C-V-Disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b DATE SIGNED 4/28/69 ADDRESS (Street, city, town, or county) 6800 Mornington Road Dundalk, Md. 21222											
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 4/29/69		23c NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery			23d LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a. REC'D BY REGISTRAR APR 30 1969		25b REGISTRAR'S SIGNATURE Melvin B. Davis			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05206

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05198

1 DECEASED NAME (Type or Print) ANNIE First MARIE Middle TAYLOR Last		2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year APR 21 69		2b HOUR 5 A.M.
3 SEX F	4 RACE C	5. DATE OF BIRTH 7-4-90	6 AGE (in years last birthday) 78 YRS	7 UNDER YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>
7a BIRTHPLACE (State or foreign country) MD.		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH BALTIMORE
10 CITY OR TOWN OF DEATH GOVANS		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 437 SCHWARTZ AVE		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE md		13b COUNTY Balto.	13c CITY OR TOWN Govans	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14 FATHER'S NAME James First Betty Middle Laura Last		15 MOTHER'S MAIDEN NAME Mitchner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO 815-12-0426		
17. INFORMANT Robert Taylor		ADDRESS 4917 Midwood Ave. Balto. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF, (b) METASTATIC CARCINOMA OF OVARY DUE TO, OR AS A CONSEQUENCE OF, (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that I took charge of the remains described above, held on death resulted from Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 4-21-69
EXAMINER'S NAME (Type) William A. Pillsbury		ADDRESS (Street, city, town, or county) Baltimore, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 4/25/69	23c NAME OF CEMETERY OR CREMATORY Pleasant Rest		23d LOCATION (City or Town) (County) (State) Towson, Balto. Co. Md.
24 FUNERAL DIRECTOR Wm. J. Chatusan		ADDRESS 7-1701 Mt. Calhoun St. Balto. Md.		25a REC'D BY REGISTRAR APR 23 1969
				25b. REGISTRAR'S SIGNATURE Charles Judge

FOR STATE
HEALTH DEPT.

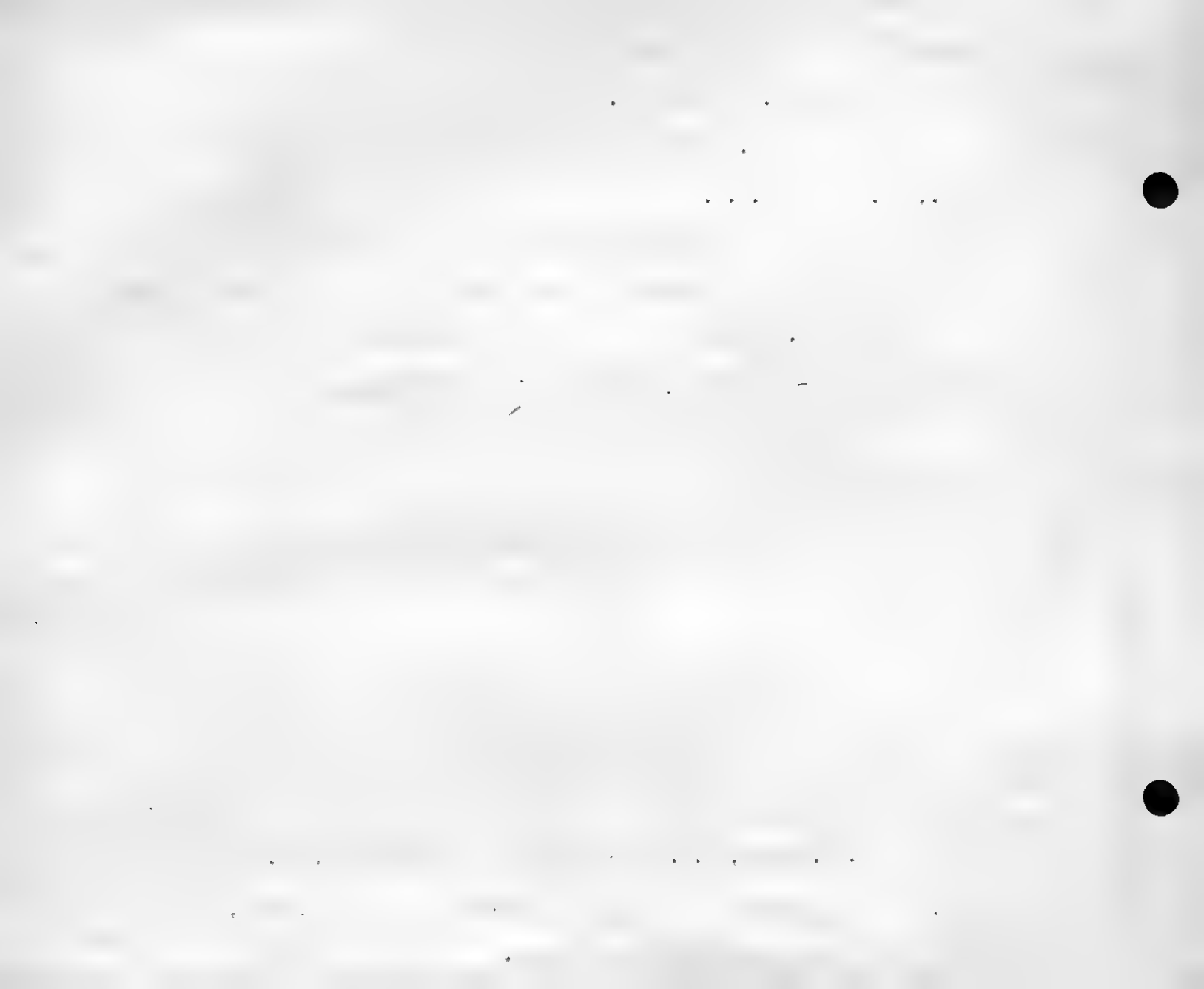
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05207

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05199

1 DECEASED NAME (Type or Print) GEORGE H. THOMAS, SR.			First Middle Last			2a DATE KNOWN OF DEATH Month Day Year 4-17-69			2b HOUR 8:00 AM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH Aug. 191887		6 AGE (In years last birthday) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (State or foreign country) Balto., Md.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore				
10 CITY OR TOWN OF DEATH Essex 21221				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 373 Walnut Grove Road				12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Steel Worker				12b KIND OF BUSINESS OR INDUSTRY Construction	
13a USUA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland				13b. COUNTY Baltimore				13c CITY OR TOWN Essex 21221		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER 373 Walnut Grove Road	
14 FATHER'S NAME Charles W. Thomas						15. MOTHER'S MAIDEN NAME Mary Elizabeth Dingle							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b SOCIAL SECURITY NO (If yes give war or dates of service) 215 01 7726		17 INFORMANT Catherin Kellner				ADDRESS Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Cancer				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE M. B. Davis				M.D. M. B. Davis, M.D. 6800 Mornington Road Dundalk, Md. 21222				22b. DATE SIGNED 4/17/69					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4/21/69				23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.						25a. REC'D BY REGISTRAR DATE APR 21 1969						25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05208 CERTIFICATE OF DEATH 05400									
1. DECEASED NAME (Type or print)			First Middle Last Harry Lester Thompson			2a. DATE OF DEATH Month Day Year April 18 1969		2b. HOUR 12 noon	
3 SEX Male		4 RACE White		5 DATE OF BIRTH 4/24/03		6 AGE (In years on last birthday) 65 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Balto., Md.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Baltimore County Md			
10 CITY OR TOWN OF DEATH Catonsville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hosp		12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Ret. Salesman		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b CITY OR TOWN Baltimore		13c INSIDE CITY (LMA 15) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 937 Vanderwood Road 21228			
14 FATHER'S NAME First Middle Last Harry Thompson			15 MOTHER'S MAIDEN NAME First Middle Last Mary Sue Anderson Thompson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO 217-05-0136		17 INFORMANT Address Records-Spring Grove State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis and diabetes</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		State
22a. I certify that (I) (this hospital) attended the deceased from <u>7/21/67</u> , 19 <u>67</u> , to <u>4/17</u> , 19 <u>69</u> , that (i) (we) last saw the deceased alive on <u>April 17</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (do) (did not) view the body after death.									
22b. SIGNATURE <i>Evelio A. Felipe MD</i>		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-18-69			
22d. PHYSICIAN'S NAME (Type) EVELIO A. FELIPE MD		22e. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-21-69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) Balto. City		(County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE APR 21 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05209 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05201

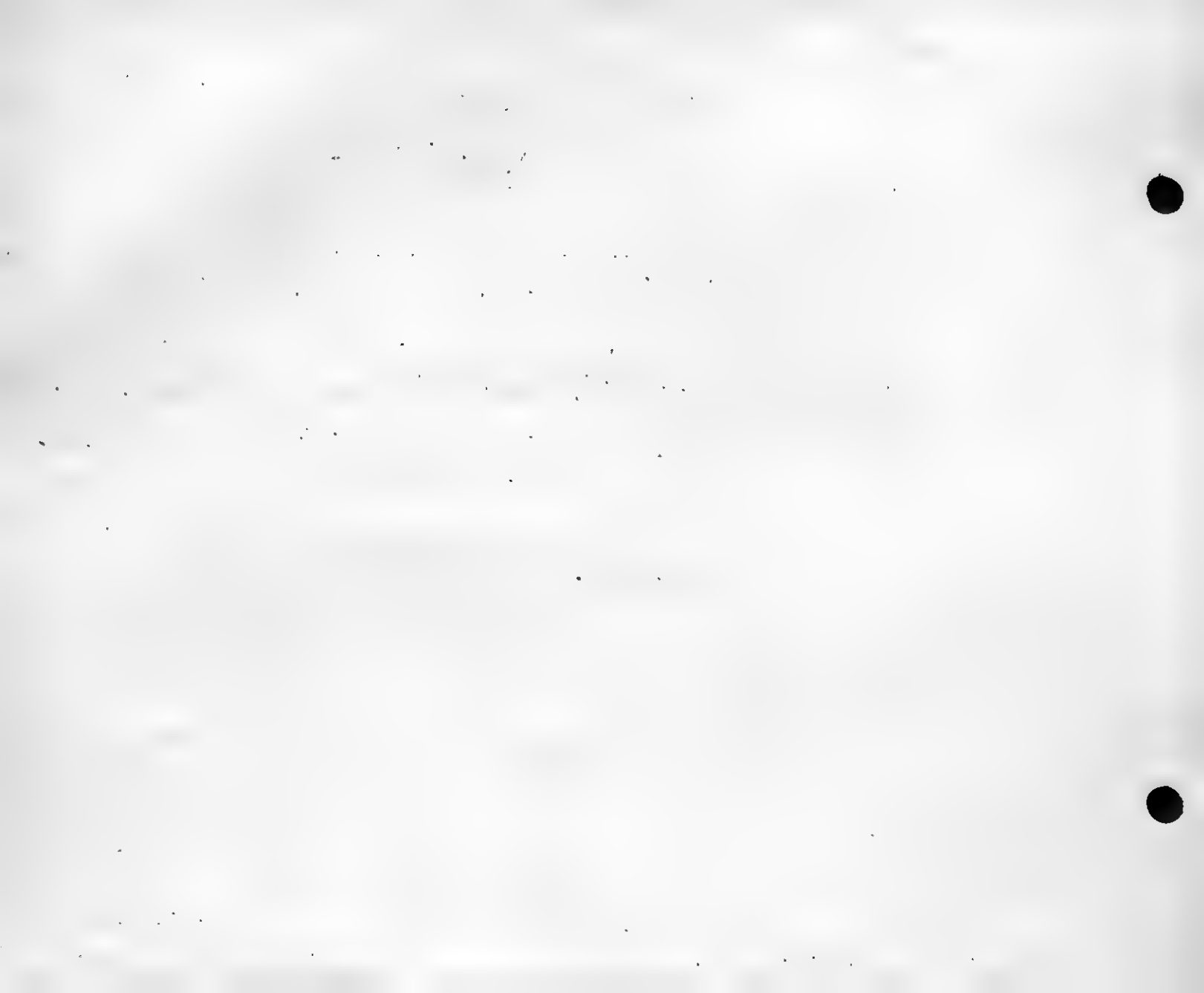
1 DECEASED NAME (Type or Print)			First SHERRY			Middle GENENE			Last TOTH			2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year			2b HOUR M								
3 SEX Female			4 RACE White			5 DATE OF BIRTH 11/30/1968			6 AGE (In years last birthday) YRS 5			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.			2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR M		
7a. BIRTHPLACE (State or foreign country) MD.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Baltimore									Md					
10. CITY OR TOWN OF DEATH ESSEX			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 948 Baynor Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY														
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN ESSEX			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET AND NUMBER 948 Baynor Road											
14 FATHER'S NAME ISHMAEL G. TOTH			First Middle Last			15 MOTHER'S MAIDEN NAME BETTY SIERAK			First Middle Last														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO —			17 INFORMANT MR. ISHMAEL G. TOTH			ADDRESS 948 BAYNOR RD														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Meningococcemia (Waterhouse-Fredrichsen Syndrome) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED 4/23/69											
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)																				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 4/26/1969			23c NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY			23d LOCATION (City or Town) (County) (State) BALTIMORE MD.														
24. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI			ADDRESS 2525 FLEET ST.			25a REC'D BY REGISTRAR APR 29 1969			25b REGISTRAR'S SIGNATURE William J. Young														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1/58

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05210									
CERTIFICATE OF DEATH									
05202									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
M. Louise Tracey						April 7 1969		9:40 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
F		Cauc.		July 7, 1892		76 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH			
Md.		U.S.A.		NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Freeland		Mt. Zion Rd. Seamsstress				Clothing Factory			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Balto. Freeland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Mt. Zion Rd.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William Still			Sophia Wirtz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No.		188-10-7637		John T. Tracey		Freeland, Md 21053			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebro-vascular accident								36 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerosis								15 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year							
(If either, notify medical examiner)		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/>									
at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 1-5-1969, to 4-7-1969, that (I) (we) last saw the deceased alive on 4-6-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Richard Robinson, M.D.								4-7-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
RICHARD ROBINSON, M.D.		NEW FREEDOM, PA.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		4/9/69		Pine Grove Cem.		Freeland-Balto.		Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James Hartenstein, New Freedom, Pa.		APR 14 1969		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>05211</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 6 Film 411 4/23/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>05203</div>									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Josephine			R		Trombetta	April 16 69			7 A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		October 6, 1892		17 76 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Italy		USA				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Holly Hill Nursing Home				Housewife			
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5511 North Charles St	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Biaggio					Russo	Philomena			? ?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				214-36-7533		Mrs Josephine Lucas 1564 Dellsway Road 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>									4 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ant sel CNS disease</u>									10 yrs
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOLING THE UNDERLYING CAUSE LAST. (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
None					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		None							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>1/4, 1960</u> to <u>4/16, 1969</u> , that (I) (we) last saw the deceased alive on <u>4/16, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED		
Maurice Feldman							4/16/69		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Maurice Feldman Jr M.D.					6610 Cross Country Blvd Baltimore, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/19/69		New Cathedral		Baltimore, Maryland			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Leonard J Ruck Inc. Baltimore, Maryland					DATE		APR 17 1969		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First JAMES			Middle D.			Last TRUMAN			2a. DATE OF DEATH Month Day Year 4-17-69			2b. HOUR 1:35		
3 SEX MALE			4 RACE CAU			5. DATE OF BIRTH 11-02-23			6. AGE (In years last birthday) 45 YRS.			F UNDER 1 YEAR MONTHS DAYS			F UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) W. VA.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH BALTIMORE CO.			Md.					
10 CITY OR TOWN OF DEATH TOWSON, MD.			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GRTR. BALTO. MED. CENTER			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY STEEL								
13a LSLAL RESIDENCE (Where deceased lived, if institut an Residence before admission) STATE MD.			13b COUNTY BALTO			13c CITY OR TOWN ESSEX			3a INSIDE CITY J.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13a STREET AND NUMBER 1141 FOXWOOD LANE					
14 FATHER'S NAME First Middle Last JAMES E. TRUMAN			15. MOTHER'S MA DEN NAME First Middle Last GRACE MYERS TRUMAN														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) UNK			16b SOCIAL SECURITY NO. 236-26-7076			17. INFORMANT Address EVELYN TRUMAN ABOVE											
18 CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, EMPYEMA 1621 DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (b) CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS. 10 MONTHS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No.			City or Town			County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-22-1969, to 04-17-1969, that (I) (we) last saw the deceased alive on APRIL 16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																	
22b SIGNATURE Richard L. Smith, M.D.			DEGREE			ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c DATE SIGNED APRIL 17, 1969								
22d. PHYSICIAN S NAME (Type) RICHARD L. SMITH, M.D.			22e ADDRESS 6701 N. CHARLES STREET														
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL			23b DATE 4/19/69			23c NAME OF CEMETERY OR CREMATORY DAK LAWN			23d LOCATION (City or Town) (County) (State) BALTO. MD.								
24 FUNERAL DIRECTOR Connolly Funeral Home			ADDRESS 300 MACE			25. REGD BY REGISTRAR APR 21 1969			25b. REGISTRAR'S SIGNATURE Charles Judge								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10)
30M REV. 1-66

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05213									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
William A. Turek						4 Month 13 Day 69 Year			M
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		7-29-03		65 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
Baltimore			U.S.A.				Baltimore (Towson) Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore			St. Joseph Hosp.			Maintenance-Sacred Heart Rectory			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LHM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Box 39 Trumps Mill Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Vaclav Turek			Katherine unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
no			215-22-4052A		Mary Zika Turek, wife, above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u>									
417 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Extensive Myocardial Infarction</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Coronary Artery Disease</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James H. Fungelson</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4-13-69 PM</u>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			4/17/69		Holy Redeemer Cemetery		Baltimore, Md.		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Shimunek Funeral Home 3331 Bohemia L.					DATE APR 15 1969		J. Charles Judge		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
MARIE			T. VALENTINE			4 Month 30 Day 69 or		1:28 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
FEMALE		NEGRO		12-29-90		78 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Va.		U.S.A.				BALTIMORE Md				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		GREAT BALT MED CENTR								
13a USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.					Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1600 Mountmor Ct.	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no and (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
no					Thaddeus Valentine 1600 Mountmor Ct.					
18 CAUSE OF DEATH (Enter only one cause per me for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONJESTIVE HEART FAILURE WITH PULMONARY EDEMA										
4123 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) MULTIPLE SMALL OLD MYOCARDIAL INFARCTS										
DUE TO, OR AS A CONSEQUENCE OF										
(c) SEVERE CORONARY ATHEROSCLEROSIS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
				12 NOON to 1:30 PM						
22a. I certify that (X) this hospital attended the deceased from 4-30, 19 69, to 4-30, 19 69, that (X) (we) last saw the deceased alive on 4-30 1 PM 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE		22c. DATE SIGNED								
Charles C. Brown, M.D.		4-30-69								
22d PHYSICIAN'S NAME (Type)		22e. ADDRESS								
CHARLES C. BROWN, M.D.		6701 N CHARLES ST, BALT, MD								
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		5-3-69		Abbutus 14em. Pk.		Baltimore, Maryland				
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REC'D BY REGISTRAR						
V.R. Bailey		MAY 2, 1969		J. J. Jones						
Kelson Funeral Home 1348 Calhoun St.										

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18

05215

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05207

1. DECEASED-NAME (Type or print) ETHEL HOLT VIVIAN			2a. DATE OF DEATH Month APRIL Day 3 Year 1969			2b. HOUR A. 6:30 M			
3 SEX Female		4. RACE White		5. DATE OF BIRTH October 25, 1878		6. AGE (In years last birthday) 90 YRS.		7. IF UNDER YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Co. Md.			
10. CITY OR TOWN OF DEATH Lutherville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) COLLEGE MANOR		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY ----		13c. CITY OR TOWN Balto. City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Wyman Park Apts.	
14. FATHER'S NAME First Middle Last William Edwin Holt			15. MOTHER'S MAIDEN NAME First Middle Last Amelia Letitia HOLT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO NO		17. INFORMANT Dauther:		Address Balto., Md.			
		213-48-4342		Ethel H.V. Chambers - 204 Ridgewood Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable mesenteric thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/16/67 , 19 67 , to 4/3/ , 19 69 , that (I) (we) last saw the deceased alive on 4/2/ , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE RK Gundry		DEGREE MD.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/4/69			
22d. PHYSICIAN'S NAME (Type) Richard K. Gundry, M.D.		22e. ADDRESS 2 W. University Parkway, 21218							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 4/8/69		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av. Balto. 1		25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05216

CERTIFICATE OF DEATH

05208

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution a Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c LENGTH OF STAY IN 1b <u>1 yr 10 mo.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Haven Nursing Home</u>		e STREET ADDRESS <u>727 McCabe Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>J</u> Last <u>Wallace</u>		4 DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1969</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 31, 1895</u>
9 AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Pickerton</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Patrick Wallace</u>		14 MOTHER'S MAIDEN NAME <u>Maria Taylor</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes War 1</u>		16 SOCIAL SECURITY NO <u>219-16-9504</u>	
17 INFORMANT <u>Richard P. Wallace</u>		Address (Son) <u>1608 Rosewick Ave. 37</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYocardial INFARCTION</u> DUE TO <u>4109</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACVD. & LEFT HEART FAILURE</u> DUE TO (c) <u>IRON DEFICIENCY ANEMIA</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>6/29, 1967</u> , to <u>4/12, 1969</u> , that (I) (we) last saw the deceased alive on <u>4/12, 1969</u> , and that death occurred at <u>9:05 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/12/69</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Smith, M.D.</u>		22d ADDRESS <u>5701 E. Main St. Baltimore, Md. 21208</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>4/15/1969</u>	23c NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Eugenia K. Seitz 5209 York Road</u>		25a REC'D BY REGISTRAR <u>APR 15 1969</u>	
<u>Seitz Funeral Home Baltimore, Maryland 21212</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
10M REV 1/69

05217

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05209

1. DECEASED-NAME (Type or Print)		First Ann	Middle B.	Last Wartman	2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> 4/27/69		2b. HOUR 8:45 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH March 1, 1909		6 AGE (in years) 60 YRS	7 UNDER YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD April 27 1969
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore	
10 CITY OR TOWN OF DEATH Colgate		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7205 Woodrow Avenue		12a. U.S.A. OCCUPATION (Kind of work done during most of working life even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Colgate		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First John		Middle Oechsler		Last Margaret		15. MOTHER'S MAIDEN NAME First Margaret	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-26-3268		17 INFORMANT (Husband) Charles H. Wartman Sr.		ADDRESS Balto. Md. 21224 7205 Woodrow Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute gastric Hem.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Theodore C. Patterson		EXAMINER'S NAME (Type) Theodore C. Patterson		M.D. M. D.		22b. DATE SIGNED 4/28/69 3724 Dundalk Ave.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE 4/30/69		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25. REC'D BY REGISTRAR APR 30 1969		25b. REGISTRAR'S SIGNATURE	



FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
RUTH Ann WATSON						Month Day Year		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
female	white	6/9/1941	27 YRS.					Month Day Year	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR
Maryland			U.S.A.				Baltimore		9:23 p.m.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson			St. Joseph's Hospital			Key puncher		Tool Mfg.	
13a. USUAL RESIDENCE (Where deceased lived, if institution, on date of death)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Harford		Monkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 99 Jarrettsville
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Walter L. Watson			Minnie Geib						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
No			214-36-8761		ADDRESS #1, Box 99 Walter L. Watson Monkton, Md. 21111				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congenital Aortic Stenosis									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			4/12/69			
Werner U. Spitz, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			4/15/1969		Bel Air Mem. Gardens		Bel Air, Harford, Md.		
24. FUNERAL DIRECTOR			ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Charles E. Kurtz			21084		APR 16 1969		W. C. Jones		
Jarrettsville, Md.									

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

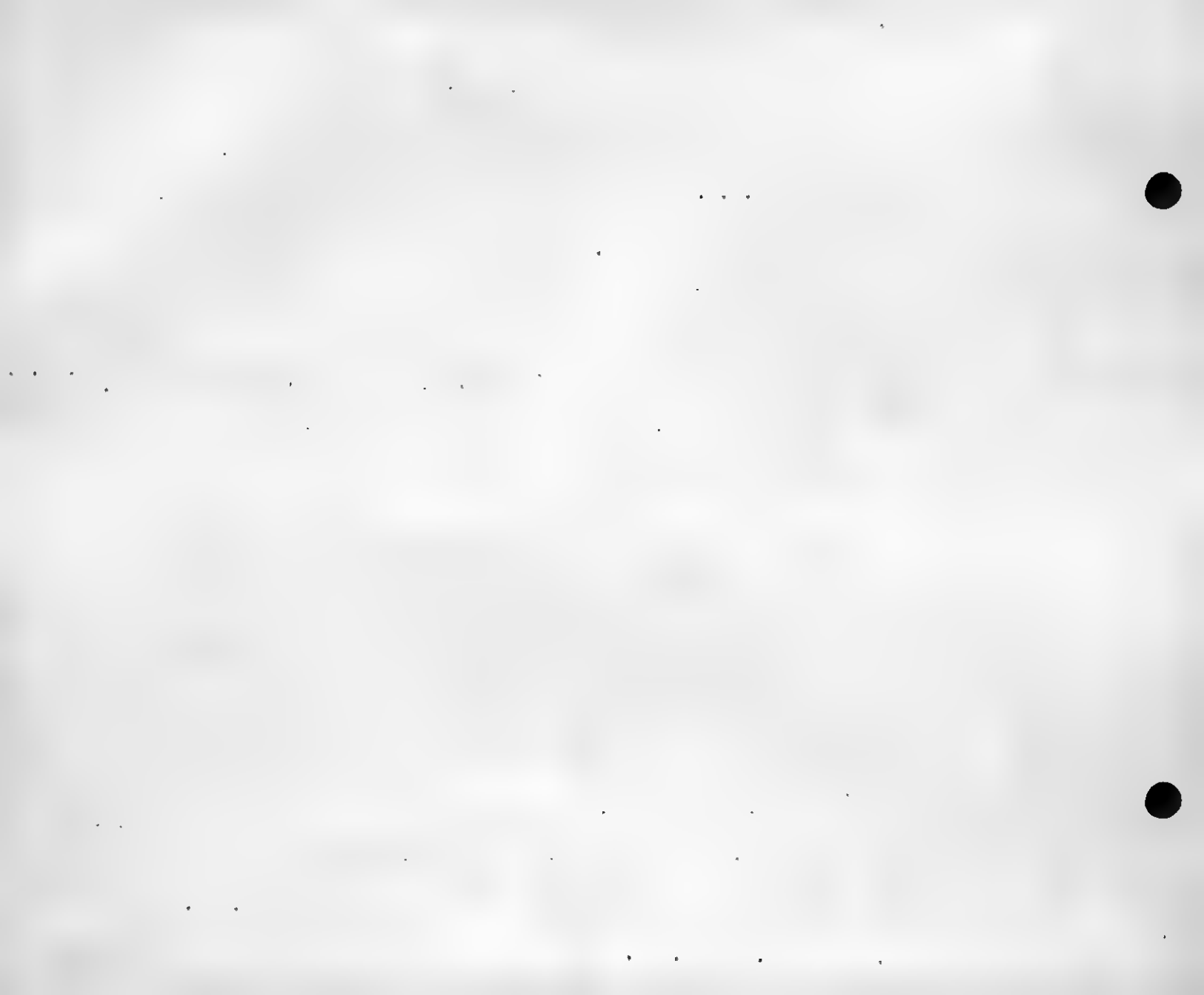
05219

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05219

1 DECEASED-NAME (Type or Print) ELSIE		First Middle Last		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> APR 17 1969		2b HOUR 10 P M
3 SEX F	4 RACE W	5 DATE OF BIRTH 5-14-05	6 AGE (In years last birthday) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year APR 17 1969
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md
10. CITY OR TOWN OF DEATH Baltimore		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph		12a. USUAL OCCUPATION (Kind of work done during most of work on date, even if retired) At Home		12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD		13b COUNTY BALTO		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME First Middle Last Ferdinand Denner		15 MOTHER'S MAIDEN NAME First Middle Last Matilda Hinck		13e STREET AND NUMBER 8214 BELAIR RD.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Dolores Surridge 932 Country Club Dr. Fayetteville, N.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE William A. Pillsbury		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 4-17-69		
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPT. MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, R.F.D., town, or county)		ADDRESS (Street, R.F.D., town, or county)				
23a B. RIAL, CREMATION REMOVAL (Specify) Burial		23b DATE 4/21/69		23c NAME OF CEMETERY OR CREMATORY Glen Haven		23d LOCATION (City or Town) (County) (State) Balto. Md.
24 FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.				25a REC'D BY REG. STRAR DATE APR 21 1969		25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) MORRIS			First Middle Last WEINER			2a. DATE OF DEATH Month APRIL Day 23 Year 1969		2b. HOUR 12:10 PM	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH FEBRUARY 5, 1882		6 AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MILFORD MANOR NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BROKER		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3600 LIBERTY HEIGHTS AVENUE	
14. FATHER'S NAME First Middle Last GERSHON WEINER			15. MOTHER'S MAIDEN NAME First Middle Last SOPHIE ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If you give year or dates of service)		17. INFORMANT Address MRS. ANNA BRANCH, 4402 OLD COURT RD., APT. D					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia 2309 DUE TO, OR AS A CONSEQUENCE OF (b) Parkinson's Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus Cardiac, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 9 years 12 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING ETC) OFFICE BUILDING ETC			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1956 to 4/23, 1969 , that (I) (we) last saw the deceased alive on 4/22, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Isaiah Zinberg MD					22c. DATE SIGNED 4/20/69				
22d. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG					22e. ADDRESS 4001 W. NORTHERN PKWY.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-24-69		23c. NAME OF CEMETERY OR CREMATORY SHOMRA MISHMERES		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					25a. REC'D BY REGISTRAR DATE APR 25 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

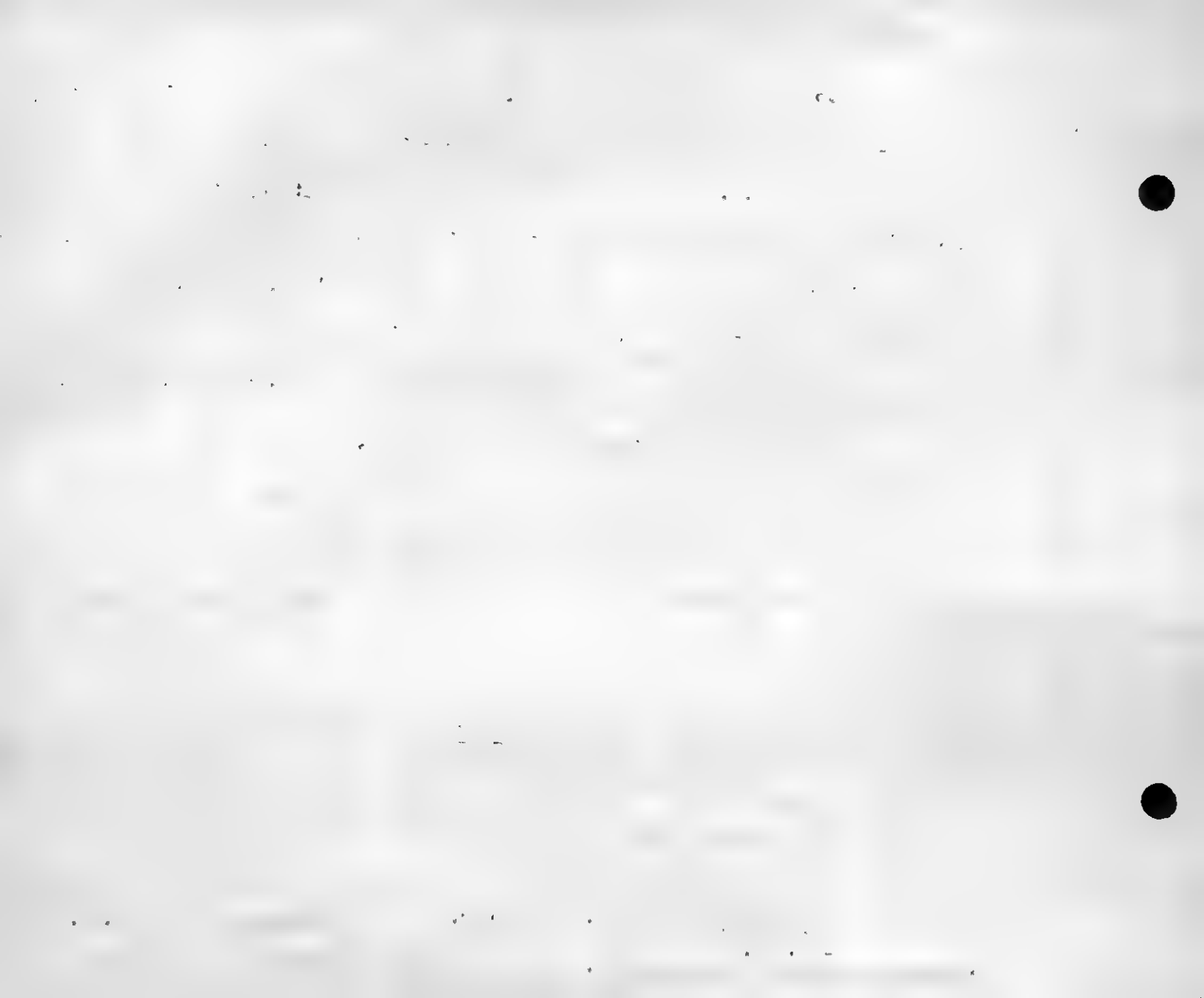
05221

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05213

1. DECEASED NAME (Type or print) Cora		First	Middle	Last	2a. DATE OF DEATH Month 4 Day 19 Year 69		2b. HOUR 2:45 P.M.				
3 SEX Female		4 RACE White		5 DATE OF BIRTH 4-9-1884		6 AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County			Md.		
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Grove State Hospital		12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY None					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 14 S. Tremont Road			
14. FATHER'S NAME Alawish		First	Middle	Last	15. MOTHER'S MAIDEN NAME Emma		First		Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes, no, or unknown)		16b. SOCIAL SECURITY NO No (If yes give year or dates of service)		17 INFORMANT Spring Grove St. Hosp. records, Catonsville		Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 485 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 12-12-68 , 19____, to 4-19 , 19 69 , that (I) (we) last saw the deceased alive on 4-19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert L. Ludwig MD				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-20-69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 23, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION (City or Town) Washington		(County) D. C.		(State)	
24 FUNERAL DIRECTOR Balto. Md. 21229				ADDRESS G. Truman Schwab 3512 Frederick Ave.		25a. REC'D BY REGISTRAR APR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

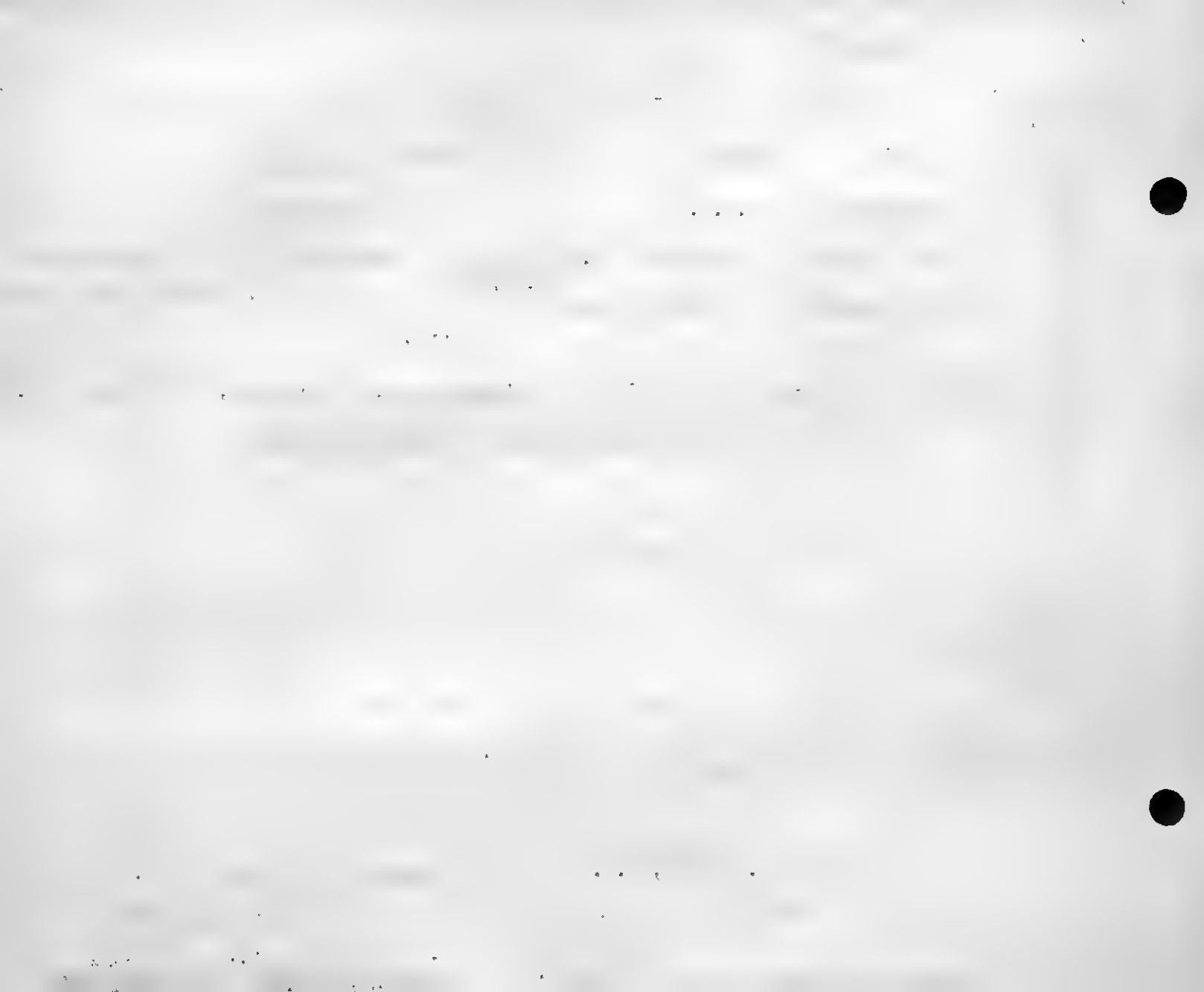


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M 1

MIDDLE											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05222											
05214											
CERTIFICATE OF DEATH											
DECEASED NAME (Type or print)		First EDGAR		Middle ---		Last WHITE		2a. DATE OF DEATH April Month 15 Day 1969 Year		2b. HOUR 9:45 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11/10/1886		6. AGE (In years last birthday) 82 YRS		F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE					
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) VETERANS ADM. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION					
13a. USUAL RESIDENCE (Where deceased lived, if institution on residence before admission) STATE MARYLAND		13b. COUNTY ANN ARUNDEL		13c. LUTHERAN HEIGHTS		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 402 N. Hammonds Ferry Road			
14. FATHER'S NAME First CHARLES		Middle ---		Last WHITE		15. MOTHER'S MAIDEN NAME First Sarah		Middle ---		Last ---	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		(If yes, give dates of service) WW-1		16b. SOCIAL SECURITY NO 220 07 2981		17. INFORMANT Clinical Rcds, VA Hospital, Fort Howard, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY 1621 IMMEDIATE CAUSE (a) CARCINOMA OF LUNGS AND BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 5 , 19 69 , to April 15 , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 15 , 19 69 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.											
22b. SIGNATURE Erhard I. Bunyor M.D.		22c. DATE SIGNED 4/16/69		22d. PHYSICIAN'S NAME (Type) ERHARD I. BUNYOR, M.D.		22e. ADDRESS VA Hospital, Fort Howard, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/18/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) Baltimore, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR WITZKE FUNERAL HOME		ADDRESS 4101 Edmondston Av.		DATE APR 17 1969		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Frank White						April 15 1969		8:00 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
M		Cauc.		Jan. 23, 1878		87		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
W. Va.		U.S.A.				Balto.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Parkton			Downes Rd.			Farmer		Own Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. STREET AND NUMBER			
Md.			Balto			Downes Rd.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
unknown			218-18-5929			Mrs Carrie Noyes, Parkton, Md. 2120			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction								5 min.	
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-3, 1962, to 4-15, 1969, that (I) (we) last saw the deceased alive on 4-4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Donald L. Bortner, M.D.				DEGREE				4-16-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
DONALD L. BORTNER				NEW FREEDOM, PA.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/18/69		Bethel Presbyterian Cem.		Jarrettsville-Harford-Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James Hartenstein				New Freedom, Pa.		APR 17 1969		James Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 23 phone call 4/11/69 from 05223												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05216			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1 DECEASED-NAME (Type or Print) First Middle Last WILLIAM P reston WHITLEY						2a DATE KNOWN OF DEATH Month Day Year April 9 1969				2b HOUR 11:55 AM									
3 SEX m		4 RACE w		5 DATE OF BIRTH 6-21-1967		6 AGE (In years, months, days) 22 years 10 months 18 days		7 IF UNDER 1 YEAR MONTHS DAYS 18 18		7 IF UNDER 24 HRS HOURS MIN 18 18		2c DATE PRONOUNCED DEAD Month Day Year April 9 1969		2d HOUR 11:55 AM					
7a BIRTHPLACE (State or foreign country) Maryland				7b CITIZEN OF WHAT COUNTRY? U. S. A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH Baltimore							
10 CITY OR TOWN OF DEATH Towson				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St Joseph Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b COUNTY Baltimore				13c CITY OR TOWN Towson		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER #21234 8524 Oakleigh Rd. 2							
14 FATHER'S NAME First Middle Last Harold Whitley						15 MOTHER'S MAIDEN NAME First Middle Last Maureen Kathleen Johnson													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b SOCIAL SECURITY NO				17 INFORMANT ADDRESS Harold G. Whitley 8524 Oakleigh Rd. 21234											
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration following DUE TO, OR AS A CONSEQUENCE OF, Choking on Aspirin Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. Sudden (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month Day, Year 5:30 PM 4/9/69				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Small keeled Aspirin											
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f LOCATION Street or RFD No City or Town County State 8524 Oakleigh Rd. Towson Baltimore											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Charles F. O'Donnell				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 4/9/69							
EXAMINER'S NAME (Type) Charles F. O'Donnell				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county) Towson, Maryland											
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b DATE 4-11-1969				23c NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens				23d LOCATION (City or Town) (County) (State) Middle River, Maryland							
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204						25a REC'D BY REGISTRAR APR 10 1969				25b REGISTRAR'S SIGNATURE Charles F. O'Donnell									

8 ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05225

CERTIFICATE OF DEATH

05217

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
ESTELLE		M.		WIGHT	April Month 25, Day 1969. Year		6 A. M.		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. IF UNDER 1 YEAR		
Female	White		December 19, 1902.		68 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Baltimore, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Middle River		Box 6, Middle River Rd.		Retired Govt. Worker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Texas				Rio Hondo		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Box 103	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Thomas		Howard		Sophia Eichelberger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No				Mrs. Norma L. Knight, Middle River Road #20					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive Cardiac Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u> <u>23 yrs.</u>		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Obesity, Diabetes Mellitus, Gen. Arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat. while at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>46</u> , to <u>4/25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Clifford F. Hudson MD</u>				22c. DATE SIGNED <u>4/27/69</u>					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
CLIFFORD F. HUDSON				FORK, MD. 21051					
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/29/69.		Baltimore National Cem.		Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck, Inc. Balto. Md. 21211				APR 28 1969		<u>Charles J. J...</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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Item 2a Film 0111 4/14/69 kk 05226 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05218

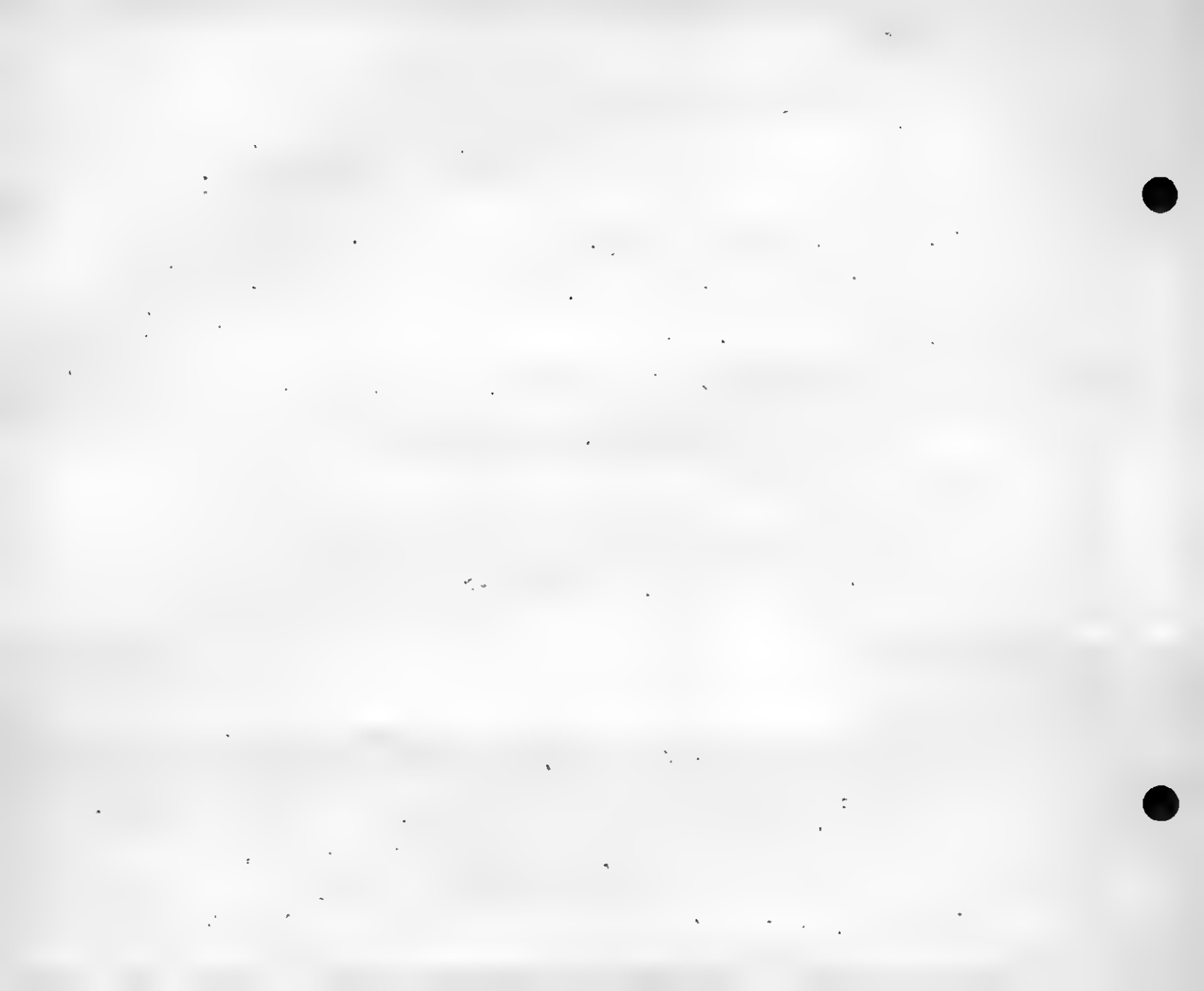
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
ERMAN			WILLIAM			WILL			Month Day Year		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
Male			White			July 22, 1909			59 YRS		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED			9. COUNTY OF DEATH		
Maryland			U.S.A.			NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
			Baltimore Gen. Hospital			Bartender					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Md.			Carroll			Sykesville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
Paul M. Will			Lucina Buckingham			No			091-16-7614		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Mrs. Geneva Will			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive and arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
Same As #13			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
20 AUTOPSY?			21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.			City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b DATE SIGNED			23a. REC'D BY REGISTRAR			23b. REGISTRAR'S SIGNATURE		
Charles S. Springate, M.D.			April 3, 1969			DATE APR 7 1969			R Charles Judge		
23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			24 FUNERAL DIRECTOR			ADDRESS		
Lakeview Memorial			Carroll, Md.			C. M. Waltz, Box 241, Sykesville, Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05227		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05219	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Edward Henry Winemiller</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>9</i> Year <i>69</i>		2b. HOUR <i>5:30 P.M.</i>		
3 SEX <i>M</i>	4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>Dec. 15, 1891</i>		6. AGE (In years last birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Balto.</i>	
10. CITY OR TOWN OF DEATH <i>Monkton</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) <i>York Rd.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Monkton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>York Rd.</i>		14. FATHER'S NAME First <i>Peter H. Winemiller</i> Middle <i>H.</i> Last <i>Winemiller</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Nading</i> Last <i>Nading</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>28-36-9246</i>		17. INFORMANT <i>Grace Winemiller, York Rd. Monkton, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>C. S. C. V. Disease</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>Carcinoma of the stomach</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1930</i> , to <i>APR 9, 1969</i> , that (I) (was) last saw the deceased alive on <i>4/8</i> 19 <i>69</i> and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A. M. France</i> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/9/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>				22e. ADDRESS <i>PARKTON, Md.</i>			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <i>4/12/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Heretford Baptist Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Parkton - Balto. - Md.</i>	
24. FUNERAL DIRECTOR <i>James Hartenstein, New Freedom, Pa.</i>				25a. REC'D BY REGISTRAR DATE <i>APR 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles L. ...</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

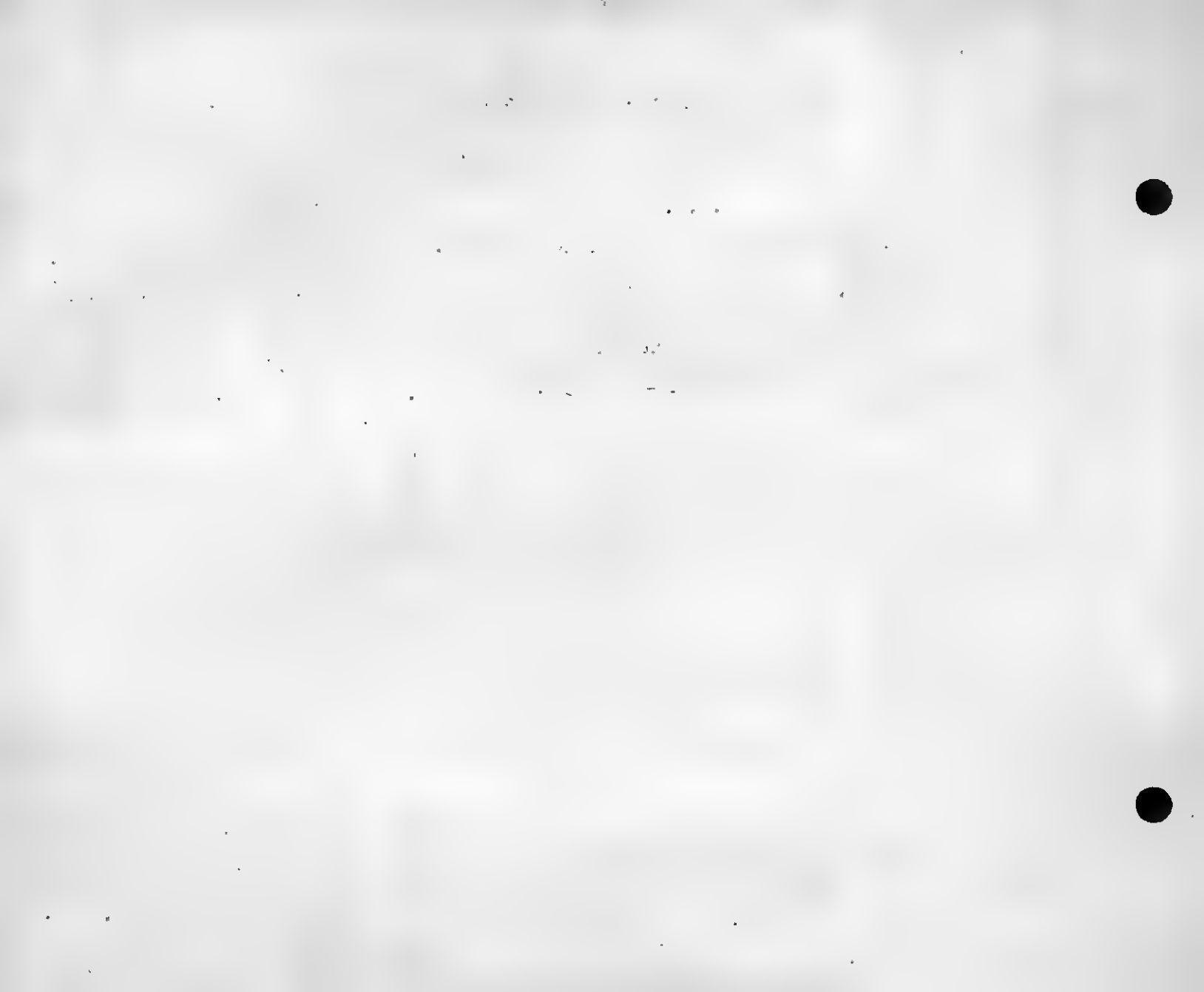
05228

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05220

1. DECEASED-NAME (Type or print) William Stanley Wollschlager			2a. DATE OF DEATH 4 Month 16 Day 69 Year			2b. HOUR M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH 6/20/1894		6. AGE (in years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Towson Fullerton (Rural)		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) St. Joseph Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Chauffeur		12b. KIND OF BUSINESS OR INDUSTRY Cab Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME First Middle Last Thomas Wollschlager		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 217-03-751318		17 INFORMANT Box 486 21162 Address White Marsh Donald W. Wollschlager Philadelphia Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4104 Cardio-respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction + Chronic Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 16 , 19 69 , to April 16 , 19 69 , that (I) (we) lost saw the deceased alive on April 16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jamie M. Punzalon				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-16-69			
22d. PHYSICIAN'S NAME (Type) Jamie M. Punzalon				22e. ADDRESS 7620 York Road					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-19-1969		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Parkville Balto. Md.			
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road 21236				ADDRESS		25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05229									
CERTIFICATE OF DEATH									
05221									
1. DECEASED-NAME (Type or print) First Middle Last Paul m NMI Wordtt					2a. DATE OF DEATH Month Day Year 4 12 69				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 06/09/03			6. AGE (In years last birthday) 65 YRS.		2b. HOUR MIN. 12:20
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4111 Priscilla Lane
14. FATHER'S NAME First Middle Last John Wordtt			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Brady						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Unknown			16b. SOCIAL SECURITY NO (If yes give war or dates of service) None		17. INFORMANT BOCH records		Address Randallstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>BENIGN HYPERTENSION</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-23, 1969</u> to <u>3-10, 1969</u> , that (I) (we) last saw the deceased alive on <u>MARCH 10, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Samuel P. Scaliardi					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-14-69		
22d. PHYSICIAN'S NAME (Type) SAMUEL P. SCALIARDI					22e. ADDRESS 2 STERNOY AVE PIKESVILLE MD.				
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE April 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or town) (County) (State) Pikesville, Baltimore Md.			
24. FUNERAL DIRECTOR Frank H. Swell, Pikesville, Md.					25a. RECD BY REGISTRAR DATE 1 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



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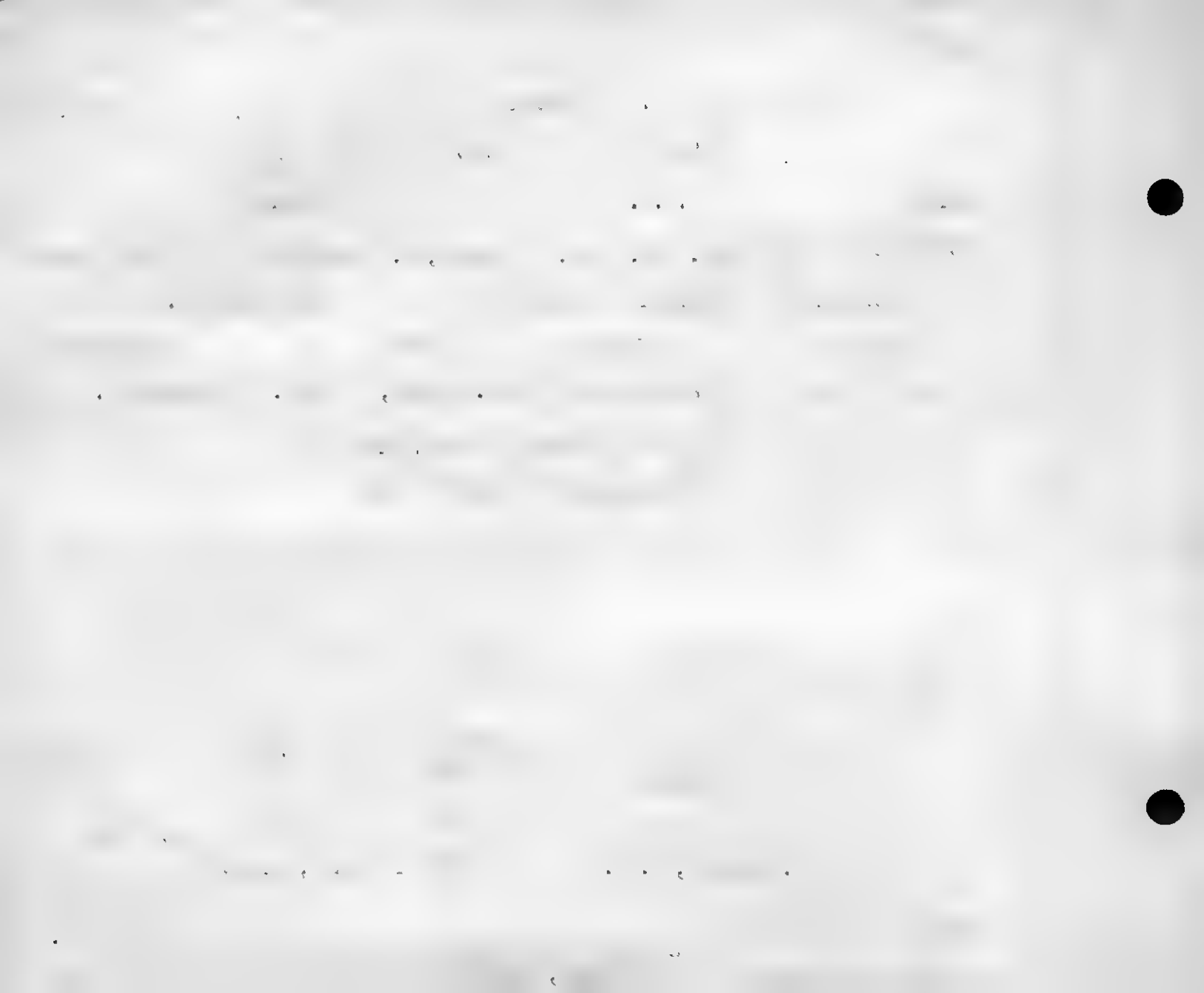


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05230 CERTIFICATE OF DEATH 05222									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
SAMUEL			B. WRIGHT			Month Day Year 4 30 69		3:15A M	
3 SEX	4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE	NEGRO		4/4/16			53 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND			U.S.A.					BALTIMORE Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
FORT HOWARD			NET. ADM. HOSP. FT HOWARD, MD.			CHAUFFEUR		CAB COMPANY	
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND			WICOMICO			SALISBURY		1010 Lake St.	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Perry			First Middle Last Sarah Robinson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT Address			
YES			WW II			218 12 19 70 CLIN. RECORDS, VA HOSP. FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) RUPTURED ANEURYSM ABDOMINAL AORTA									
DUE TO, OR AS A CONSEQUENCE OF									
(b) ARTERIOSCLEROSIS GENERALIZED									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (he/she) attended the deceased from 4/12/69, 19, to 4/30/69, 19, that (s/he) lost saw the deceased alive on 4/30/69, 19, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
J. D. Talbert, MD						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		4/30/69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
JOHN D. TALBERT, M. D.						VAH FT HOWARD, MARYLAND			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL			5/3/ 69			Green Acres		Salisbury Wicomico Md.	
24. FUNERAL DIRECTOR			25a. REC'D BY REG. STRAR			25b. REGISTRAR'S SIGNATURE			
Clinton E. Stewart			STEWART FUNERAL HOME			MAY 5 1969		Charles Judge	
SALISBURY, MARYLAND									



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05231

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05223

1. DECEASED-NAME (Type or print) WILLIAM VICTOR WRIGHTSON			2a. DATE OF DEATH Month 4 Day 15 Year 1969			2b. HOUR 3:45 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11-12-85		6. AGE (In years last birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore County, Md.	
10. CITY OR TOWN OF DEATH Mount Wilson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson St. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STEEL WORKER RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4833 PARK HEIGHTS AVE.							
14. FATHER'S NAME First FRANCIS Middle WRIGHTSON Last ALICE DAWSON			15. MOTHER'S MAIDEN NAME First ALICE DAWSON Middle ALICE DAWSON Last ALICE DAWSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 219-20-2844		17. INFORMANT Address Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 CONGESTIVE HEART FAILURE, pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease, DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Accident, left hemiplegia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) generalized arteriosclerosis, peripheral vascular diseases							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. Newcomer				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.				22e. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-17-1969		23c. NAME OF CEMETERY OR CREMATORY SPRINGHILL CEMETERY		23d. LOCATION (City or Town) (County) (State) EASTON TALBOT MD.	
24. FUNERAL DIRECTOR R. ELIS CLARK				ADDRESS EASTON, MARYLAND		25a. REC'D BY REGISTRAR APR 21 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

1. Official Record

2. Official Record

3. Official Record

4. Official Record

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28. Official Record

29. Official Record

30. Official Record

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<div style="display: flex; justify-content: space-between;"> 05232 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05224 </div>													
1. DECEASED-NAME (Type or print) XXXXXXXX ^{First} Antone ^{Middle} NMI ^{Last} Yienger						2a. DATE OF DEATH 4 Month 27 Day 69 Year			2b. HOUR M				
3. SEX male		4. RACE white		5. DATE OF BIRTH 3-27-90			6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Balto. Co. Md.				
10. CITY OR TOWN OF DEATH Randallstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Balto. Co. General Line 0 Type				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3547 Milford Mill Rd.			
14. FATHER'S NAME ^{First} John ^{Middle} NMI ^{Last} Yienger				15. MOTHER'S MAIDEN NAME ^{First} unknown ^{Middle} Rosenberg ^{Last} Rosenberg									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-01-5372 A			17. INFORMANT Grave Yienger				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Pulmonary edema - Respiratory Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic and heave pericarditis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HRS MO-YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>CA of Prostate with metastases to lymph nodes</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Sumner Call, MD</u> ^{DEGREE} ^{ATTENDING PHYS.} <input type="checkbox"/> ^{MED. DIRECTOR} <input type="checkbox"/> ^{STAFF PHYS.} <input type="checkbox"/>								22c. DATE SIGNED 4-27-69					
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE May 1, 1969		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Loring Byers 8728 Liberty Road 21133								25. DIED BY REGISTRAR APR 30 1969 DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



Differs following items - [illegible]
Please call [illegible] [illegible]

Case [illegible] with [illegible] to [illegible]

James Hill, III
[illegible]